SANTÉ PHYSICIANS

PROVIDER DISPUTE RESOLUTION REQUEST

Send to:
Cost Containment Department
P.O. Box 792, Fresno, CA 93712
Or
Fax to: (559) 224-2672

Provider Name:	Provider Tax ID #:
Provider Address:	Contracted? ☐ Yes ☐ No

Patient Name:		Date of Birth:
Social Security Number:	Subscriber ID #:	Claim Number:
Service " From – To" Date:	Original Billed Amount:	Claim Amount Paid:

Claim Information: ☐ Single Claim ☐ Multiple "LIKE" claims (attach spreadsheet)

Dispute Type: ☐ claim ☐ Appeal of Medical Necessity ☐ Contract Dispute ☐ Seeking Resolution of a Billing Determination ☐ Disputing a Request for Reimbursement of Overpayment ☐ Other

Description of Dispute: (INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND BASIS THEREFOR)
Additional paper can be attached if necessary

Expected Outcome: (please provide by claim if multiple)

Contact Name (Print)	Title	Area code & Phone Number
Signature and date	Email Address	Fax Number

PROVIDER DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims)

Number	PT. Last Name	Pt. First Name	Date of Birth	Health Plan Id #	Original Claim #	Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

❑ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED