

Provider Dispute Resolution Request

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE MEMBER

INSTRUCTIONS — PLEASE READ CAREFULLY AND CHECK OFF EACH ITEM

- Please complete the form in its entirety. Incomplete requests will be returned to your office.
- Please be specific when completing the "Description of Dispute" and "Expected Outcome" sections. You may attach more detailed information if needed.
- Please attach a copy of the original CMS 1500 or UB-04 claim form along with any applicable explanation of benefits (EOBs).
- Please provide additional information to support your dispute (e.g., chart notes, physician orders, authorization).
- Please use the "Provider Inquiry Request" form for routine follow-up and status checks. Call (951) 791-1111 with questions.
- Please mail the completed form with all attachments to the address shown below.

Please mail the completed form to:

Nivano Physicians
 ATTN: Provider Disputes
 890 W. Stetson Ave.
 Hemet, California 92543

PROVIDER INFORMATION

PROVIDER NAME		PROVIDER TAX ID #	
PROVIDER ADDRESS		STATE LICENSE # (IF APPLICABLE)	
CONTACT NAME (PLEASE PRINT)	PHONE NUMBER	FAX NUMBER	
CONTACT SIGNATURE		CONTACT TITLE	

PROVIDER TYPE

- | | | | | |
|------------------------------|--|--------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> MD | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Hospital | <input type="checkbox"/> ASC | <input type="checkbox"/> SNF |
| <input type="checkbox"/> DME | <input type="checkbox"/> Rehab | <input type="checkbox"/> Home Health | <input type="checkbox"/> Ambulance | <input type="checkbox"/> Other: _____ |

CLAIM INFORMATION

- Single Claim Multiple "Like" Claims (attach spreadsheet) Number of Claims: _____

MEMBER NAME	HEALTH PLAN
MEMBER ID #	DATE OF BIRTH
DATE OF SERVICE	TOTAL BILLED CHARGES
ORIGINAL CLAIM #	ORIGINAL CLAIM AMOUNT PAID

DISPUTE TYPE

- | | |
|--|---|
| <input type="checkbox"/> Claim | <input type="checkbox"/> Seeking Resolution of a Billing Decision |
| <input type="checkbox"/> Appeal of Medical Necessity / UM Decision | <input type="checkbox"/> Contract Dispute |
| <input type="checkbox"/> Request for Reimbursement of Overpayment | <input type="checkbox"/> Other: _____ |

DESCRIPTION OF DISPUTE
Indicate reason for dispute, provider's position and basis. Additional information may be attached if necessary.

EXPECTED OUTCOME
Please provide per claim if submitting multiple claims.