PromiseCare Medical Group

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.
- ☐ Please mail the completed form with all attachments to the address shown below.

Please mail the completed form to:

PromiseCare Medical Group
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

☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF
☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ 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

☐ Claim
☐ Appeal of Medical Necessity / UM Decision
☐ Request for Reimbursement of Overpayment
☐ Seeking Resolution of a Billing Decision
☐ Contract Dispute
☐ 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.