PROVIDER DISPUTE RESOLUTION REQUEST

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

INSTRUCTIONS *(Please read carefully and check off ☑ form)*

☐ 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 of this form. 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 (EOB's).

☐ Please provide additional information to support your dispute. This information may include, but is not limited to, chart notes, physician orders, authorization, etc.

☐ For routine follow-up, including status checks, please use the "Provider Inquiry Request" form instead of this form. Please call (951) 791-1111 if questions.

☐ Please mail the completed "Provider Dispute Resolution Request" form with all attachments to:

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

Provider Name:	Provider Tax ID #:
Provider Address:	State License # *(if applicable)*:
Contact Name *(please print)*:	Phone Number: ( ) Fax: ( )
Contact Signature:	Contact Title:

Provider Type: ☐ MD   ☐ Mental Health   ☐ Hospital   ☐ ASC   ☐ SNF   ☐ DME   ☐ Rehab
☐ Home Health   ☐ Ambulance   ☐ Other _____

Claim Information: ☐ Single ☐ Multiple "Like" Claims (complete the attached 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 therefore. Additional information can be attached if necessary)*:

Expected Outcome *Please provide per claim if multiple)*: