PROVIDER DISPUTE RESOLUTION REQUEST

blue california
Promise Health Plan

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- Mail the completed form to:

Blue Shield of California Promise Health Plan
FirstSource – BSCPHP PDR
PO Box 8309
Chico, CA 95927-8309

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

PROVIDER TYPE: ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE"** Claims (complete attached spreadsheet) Number of claims: ____

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE:

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request for Reimbursement of Overpayment
☐ Seeking Resolution of a Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print) | **Title** | **Phone Number**

Signature | **Date** | **Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple.)**

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

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For use with multiple "LIKE" claims (claims disputed for the same reason)

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	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple.)**