Blue Shield of California

# provider dispute resolution request

**Instructions**

Provider disputes must be submitted in writing to:

Blue Shield Dispute Resolution Office
Attn: Medicare Advantage
P.O. Box 272640
Chico, CA 95927-2640

| **Provider name** | **Provider ID** (Blue Shield PIN, provider's tax ID, or SSN) |
|---|---|
| **Contact information** (mailing address and phone number) | |

**Claim information** ☐ Single ☐ Multiple claims (complete attached worksheet)
**Claim Number:**

| **Patient name** | **Patient date of birth** |
|---|---|
| **Subscriber No.** | **Service from/to date** |
| **Submitters name** | **Today's date** |

**Dispute type**

☐ **BENEFITS**
- ☐ Benefit Coverage
- ☐ Benefits Maximum
- ☐ Member Liability
- ☐ Pre-Existing Condition

☐ **ELIGIBILITY**
- ☐ Ineligible Member with Valid Auth
- ☐ Patient Eligibility
- ☐ Retro-Activation Eligibility

☐ **NON-CLAIM RELATED**
- ☐ Contract Effective Date
- ☐ Provider Eligibility
- ☐ Provider Manual/Other Policy/Terms

☐ **CLINICAL**
- ☐ Blue Shield Medical Policy
- ☐ Length of Stay / Level of Care
- ☐ No Authorization
- ☐ Partial/Insufficient Authorization
- ☐ Valid Authorization on File

☐ **COORDINATION OF BENEFITS (COB)**
- ☐ Blue Shield Secondary Payer
- ☐ COB payment structure

☐ **OVERPAY RECOVERY**
- ☐ Recoupment of Claim Overpayment

☐ **TIMELY SUBMISSION**
- ☐ Timely Filing Limit of Initial/Final Appeal Submission
- ☐ Timely Filing Limit of Claim Submission

☐ **PROFESSIONAL CONTRACTUAL REIMBURSEMENT**

- ☐ ACS/Home Healthcare/Infusion
- ☐ Anesthesia
- ☐Assistant
- ☐ Chemo (Admin/Drugs/Injectables)
- ☐ Diagnostic Testing
- ☐ DME/HME/Supplies
- ☐ Emergency Services
- ☐ Family Planning
- ☐ Fetal Genetic Testing
- ☐ Gould Criteria
- ☐ Immunizations (Adult/Child)
- ☐ Laboratory/Radiology/Ancillary
- ☐ Letter of Agreement / Reasonable & Customary / Continuity of Care
- ☐ Maternity
- ☐ Modifier
- ☐ Office Visit/Consultation
- ☐ Pharmaceuticals/Injections/Drugs
- ☐ Psychiatric/ Substance Abuse
- ☐ Special Pricing
- ☐ Surgery
- ☐ Therapy Services
- ☐ Transplant/Global Period
- ☐ Units of Service

☐ **DIVISION OF FINANCIAL RESPONSIBILITY (DOFR)**

- ☐ Ambulance
- ☐ Blood Transfusions/Products
- ☐ Cancer Clinical Trial
- ☐ Chemotherapy (Admin/Drugs/Injectables)
- ☐ Detox
- ☐ Diagnostic Testing
- ☐ DME/HME/Supplies
- ☐ ER Services (In Area)
- ☐ ER Services (Out of Area)
- ☐ False Labor Check
- ☐ Family Planning
- ☐ Fetal Genetic Testing
- ☐ Fetal Monitoring
- ☐ Immunizations, Adult/Child
- ☐ Infusion
- ☐ Invasive Cardiology/Surgical
- ☐ Lab/Radiology/Ancillary Services
- ☐ Maternity Pre & Post/Delivery
- ☐ Office Visit/Consultation
- ☐ POS Opt-Out
- ☐ Pre Admission Testing
- ☐ Psychiatric/Substance Abuse
- ☐ Renal Dialysis
- ☐ Surgery
- ☐ Therapy Services (PT, OT, RT, ST, Cardiac)
- ☐ Urgent Care (In Area)
- ☐ Urgent Care (Out of Area)

☐ **PROFESSIONAL PAYMENT LOGIC**

- ☐ Age/Gender
- ☐ Assistant
- ☐ CCI Incidental
- ☐ CCI Mutually Exclusive
- ☐ Duplicate
- ☐ Invalid Codes
- ☐ Maximum Daily Allowances
- ☐ Pay Percent Application
- ☐ Pre/Post Operative Visits included in Surgical Charge
- ☐ Rebundling
- ☐ Scope of Licensure

**Additional explanation of issue:**

☐ Check here if additional information is attached.

If submitting multiple claims (on the next page), please fill in before clicking print button.

## Multiple claim information

| | | |
|---|---|---|
| **1** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **2** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **3** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **4** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **5** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **6** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **7** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **8** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **9** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |
| **10** | Last name | First name |
| | Date of birth | Subscriber No. |
| | Original claims No. (ICN) | Service from/to date |
| | Expected outcome | |