



PROSPECT  
MEDICAL

## PROVIDER DISPUTE RESOLUTION REQUEST

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

### 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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form. Mail the completed form to: Prospect Medical Provider Disputes Department  
1920 E. 17<sup>th</sup> Street, Ste 200, Santa Ana, CA 92705

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / Medicare ID #:</b>
<b>PROVIDER ADDRESS:</b>	

**PROVIDER TYPE**     MD     Mental Health     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:* \_\_\_\_

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

<b>DISPUTE TYPE</b>	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

_____	_____	( ) _____
<b>Contact Name (please print)</b>	<b>Title</b>	<b>Phone Number</b>
_____	_____	( ) _____
<b>Signature</b>	<b>Date</b>	<b>Fax Number</b>

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED  
 (Please do not staple additional information)

<i>For Health Plan Use Only</i>
TRACKING NUMBER
PROVIDER ID#



**PROSPECT  
MEDICAL**

## PROVIDER DISPUTE RESOLUTION REQUEST (For use with multiple "LIKE" claims)

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

Number	* 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	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED  
(Please do not staple additional information)