PROVIDER DISPUTE RESOLUTION REQUEST

Mail to:
MHN Provider Appeals/Dispute
P.O. BOX 989882
West Sacramento, CA
95798-9882

INSTRUCTIONS

- Please complete the form below. Fields with an asterisk (*) are always required.
- Fields with a double asterisk (**) are required for Claim, Billing and Reimbursement of Overpayment Disputes.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.

*PROVIDER NAME:	*PROVIDER TAX ID # :
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD/DO ☐ 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*:___

* Patient Name:		Date of Birth:
* Subscriber ID Number:	Patient ID Number:	**Original Claim Form ID Number: (If multiple claims, attachMultiple Claim Spreadsheet)
**Service "From/To" Date:	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ 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 additional information)

For MHN Use Only
TRACKING NUMBER
PROVIDER ID#