PROVIDER DISPUTE RESOLUTION REQUEST

Mail to: MHN
Provider Dispute
P.O. BOX 10697
San Rafael, CA 94912

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#