



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, attach Multiple Claim Spreadsheet) | |
| **Service "From/To" Date: | Original Claim Amount Billed: | Original Claim Amount Paid: | |

DISPUTE TYPE

| | |
|--|--|
| <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:**

| | | |
|------------------------------------|--------------|---------------------|
| _____ | _____ | _____ () |
| Contact Name (please print) | Title | Phone Number |
| _____ | _____ | _____ () |
| Signature | Date | Fax Number |

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

| |
|-------------------------|
| <i>For MHN Use Only</i> |
| TRACKING NUMBER _____ |
| PROVIDER ID# _____ |