PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims batched by similar issue with one Provider Claims Dispute Resolution Request form completed for each batch)

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.
- Mail the completed form to: Claims Department – Kern Family Health Care
  2900 Buck Owens Boulevard
  Bakersfield, CA 93308-6316

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

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*:___

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	***Original Claim Document Number:** (If multiple claims, use attached spreadsheet)
***Service "From/To" Date:**	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE: First Level _____ Second Level ______

☐ Claim

☐ Seeking Resolution Of A Billing Determination

☐ Appeal of Medical Necessity / Utilization Management Decision

☐ Request For Reimbursement Of Overpayment

*** DESCRIPTION OF DISPUTE (**must include a clear explanation of the basis upon which you believe KHS' action is incorrect)**:**

EXPECTED OUTCOME:

		( )
***Contact Name (please print)**	**Title**	***Phone Number**
		( )
Signature	**Date**	***Fax Number**

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim Document Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
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