KERN HEALTH SYSTEMS – KERN FAMILY HEALTHCARE
PROVIDER CLAIMS 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.
- 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**

If you have not received a response to this dispute within 45 working days, please call the Claims Department:

(800) 391-2000.

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)

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								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								