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
  PO Box 85000
  Bakersfield, CA 93380-9998

***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, option 5, then 3.

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								