PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: NOT FOR DISPUTES REGARDING CLAIMS PAYMENT OR AUTHORIZATION

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: Provider Network Management –Kern Family Health Care
  2900 Buck Owens Blvd
  Bakersfield, Ca 93308

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

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

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

EXPECTED OUTCOME:

_____	_____	_____
Contact Name:	Title:	Phone Number:
_____	_____	_____
Signature:	Date:	Fax Number:

Kern Family Health Care received this dispute on _____. If you have not received a response to this dispute within 45 working days, please call the Provider Relations Department at 1-800-391-2000.

_____(signature)
Acknowledgement of Receipt