Santa Clara Family Health Plan

Provider Dispute Form

Claims, Medical, and Administrative Disputes

Phone: **1-408-874-1788**

Today's Date:_____

Submit provider disputes through Santa Clara Family Health Plan's online form or mail this completed form to: **Santa Clara Family Health Plan, Attn: Provider Dispute Resolution Unit, P.O. Box 18880, San Jose CA 95158.**

- Fields with an asterisk (*) are required.
- Be specific when completing the "Description of Dispute" and "Expected Outcome."
- Provide additional infromation to support the description of the dispute. Do not include a copy of a claim that was previously processsed.
- Multiple "Like" claims are for the same provider and dispute but different members and dates of service. If filing multiple "Like" claims please complete this form and comlete the Multiple "Like" Provider Dispute Form found on the SCFHP provider forms web page.
- For routine follow-up status, instead of the Provider Dispute Resolution Form, please call SCFHP at **1-408-874-1788.** Independent providers can check claims status online at **www.scfhp.com**.

Provider Information

*Provider NPI:_____ *Provider Tax ID #:_____

*Provider Name:_____

Address to which SCFHP should respond:_____

Provider Type: ☐ MD ☐ Mental Health Professional ☐ Hospital ☐ ASC ☐ SNF ☐ DME
☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other: _____

Claim Information

*Patient Name:_____ Date of Birth: _____

*Member ID #:_____ Original Claim #: _____

Patient Account #:_____Billed Amount:_____Date of Service:_____

Dispute Type: ☐ Claim ☐ Contract Dispute
☐ Seeking resolution of a billing determination
☐ Appeal of medical necessity/utilization management decision
☐ Disputing request for reimbursement of overpayment
☐ Other: _____

*Description of Dispute:

Expected Outcome:

Contact Information

Contact Name (Please Print):_____ Title: _____

Signature:_____ Date: _____

Phone Number: _____ Fax Number: _____