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 information 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 mulitiple "Like" claims please complete this form and comlete the Mulitple "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: ______________________

40065