PROVIDER DISPUTE RESOLUTION REQUEST

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. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to:

Sharp Health Plan
Attn: Provider Dispute Resolution
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax Number: (858) 636-2276

PRODUCT TYPE:		**COMMERCIAL**		**MEDI-CAL**		**MEDICARE**

***PROVIDER NPI:**		**PROVIDER TAX ID:**	
***PROVIDER NAME:**			
PROVIDER ADDRESS:			

PROVIDER TYPE:					
	MD		ASC		Rehab
	Mental Health Professional		SNF		Home Health
	Mental Health Institutional		DME		Ambulance
	Hospital		Other, specify		

CLAIM INFORMATION:		Single		Multiple	Number of Claims	
"LIKE" Claims (complete attached spreadsheet)						
CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)						

***** **Patient Name:**		**Date of Birth:**	
***** **Health Plan ID Number:**			
* **Patient Account Number:**			
***** **Original Claim ID Number:** (If multiple claims, use attached spreadsheet)			
***** **Service "From/To" Date:** (Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)		**Original Claim Amount Billed:**	
		Original Claim Amount Paid:	

COMMERCIAL AND MEDI-CAL DISPUTE TYPE:			
	Claim		Downcoding / Payment
	Appeal of Medical Necessity/Utilization Management Decision		Seeking Resolution of a Billing Determination
	Contract Dispute		Other, Specify
	Disputing Request For Reimbursement of Overpayment		
MEDICARE DISPUTE TYPE:			
	Medicare Fee Schedule Payment Dispute		
***** **DESCRIPTION OF DISPUTE:**			
EXPECTED OUTCOME:			

Contact Name (please print)	**Title**	**Phone Number**
Signature	**Date**	**Fax Number**

For Health Plan / RBO Use Only			
TRACKING NUMBER		CONTRACTED	
PROV ID #		NON-CONTRACTED	

ICE Approved 10/5/07, effective 1/1/08, revised 2014, revised 2/24/22

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID 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								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								

ICE Approved 10/5/07, effective 1/1/08, revised 2014, revised 2/24/22

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, timeframes, and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:				
PROVIDER ID OR NPI #:				
a. PROVIDER NAME				
b. CONTRACTED PROVIDER		**YES**		**NO**
c. DATE DISPUTE RECEIVED (Date Stamped):				
d. DATE OF INITIAL PAYMENT OR ACTION:				
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d)		**YES**		**NO**
	(If No, should be returned to provider without action)			

f.1 COMMERCIAL OR MEDI-CAL DISPUTE TYPE:			
	Claim		Downcoding / Payment
	Appeal of Medical Necessity/Utilization Management Decision		Seeking Resolution of a Billing Determination
	Contract Dispute		Other, Specify
	Disputing Request For Reimbursement of Overpayment		
f.2 MEDICARE DISPUTE TYPE:			
	Medicare Fee Schedule Payment Dispute		

f.3 PROVIDER TYPE:		PROFESSIONAL		INSTITUTIONAL		OTHER
g. DATE DISPUTE ACKNOWLEGED:			**h. TURNAROUND TIME (g – c)**			

i. TYPE OF LETTER SENT: (List the various HICE letters as applicable)	

IF NO ADDITIONAL INFORMATION REQUESTED:		
j. DATE OF ACTION:		
k. ACTION TURNAROUND TIME (j – c)**:**		
l. TYPE OF ACTION:		UPHELD
		OVERTURNED
		OTHER

IF ADDITIONAL INFORMATION REQUESTED:		
m. DATE ADDITIONAL INFO REQUESTED:		
n. TURNAROUND TIME (m – c)**:**		
o. DATE ADDITIONAL INFO REQUESTED:		
p. RECEIPT TURNAROUND TIME (o - m)**:**		
q. DATE OF ACTION:		
r. ACTION TURNAROUND TIME (q - o)**:**		
s. TYPE OF ACTION:		UPHELD
		OVERTURNED
		OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:	

ACTION: (If decided in whole or part on behalf of provider, apply appropriate interest to payment or partial payment and make payment within 5 days of issuing determination)	