Anthem BlueCross

Medi-Cal Managed Care
Medi-Cal Access Program
L. A. Care
Major Risk Medical Insurance Program

Provider Dispute Resolution Request

Submission of this form constitutes agreement not to bill the patient during the dispute process.

- Please complete the form below. 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.
- For routine follow-up, please use the Claims Follow-Up Form.
- Mail the completed form to: **Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007**

Provider Name*: _____

Tax ID Number: _____

National Provider Identifier (NPI) Number: _____ Rendering Provider NPI Number: _____

Street Address: _____

City: _____ State: _____ ZIP code: _____

Provider Type: ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF
☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance
☐ Other (please specify): _____

CLAIM INFORMATION

☐ Single ☐ Multiple "LIKE" Claims (complete page 2) Number of Claims: _____

Patient Name*: _____ Date of Birth: _____

Health Plan ID Number*: _____ Patient Account Number: _____

Original Claim ID Number (if multiple claims, complete page 2): _____

Service "From/To" Dates* (required for claim, billing, and reimbursement of overpayment disputes): _____ / _____

Original Claim Amount Billed: _____ Original Claim Amount Paid: _____

DISPUTE TYPE

☐ Claim ☐ Seeking Resolution of a Billing Determination ☐ Contract Dispute
☐ Request For Reimbursement of Overpayment ☐ Appeal of Medical Necessity / Utilization Management Decision

☐ Other (please specify): _____

Description of Dispute*: _____

_____

_____

Expected Outcome: _____

Contact Name (please print): _____ Title: _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

☐ **Check here if medical records are attached.** Please do not staple medical records to this form.

☐ **Check here if additional information is attached.** Please do not staple additional information.

For Health Plan Use Only Tracking Number: _____ Provider ID #: _____
☐ Contracted Provider ☐ Non-Contracted Provider

Multiple "LIKE" claims are when the claim is for the same provider, same dispute, and different members. Fields with an asterick (*) are required.

Provider Name*: _____ NPI Number: _____ Rendering Provider NPI Number: _____

Street Address: _____ City: _____ State: _____ ZIP code: _____

Number	*Patient Name		Date of Birth	Health Plan ID Number*	Original Claim ID Number	Service From/To Date	Original Claim Amount	Original Claim Amount Paid
	Last	First						
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								

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☐ **Check here if additional information is attached.** Please do not staple additional information.