

# PROVIDER DISPUTE RESOLUTION REQUEST

**Note: Submission of this form constitutes agreement not to bill the patient**

**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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Meritage Medical Network Attn: Provider Dispute Resolution Intake Coordinator  
4 Hamilton Landing, Suite 100  
Novato, CA 94949

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

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

\*CLAIM INFORMATION    Single    Multiple "LIKE" Claims (complete attached spreadsheet) Number of claims: \_\_\_\_

*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:

DISPUTE TYPE

<input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity/Utilization Management Decision <input type="checkbox"/> Request for Reimbursement of Overpayment	<input type="checkbox"/> Seeking Resolution of a Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Other:
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\*DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

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

[ ] Check here if additional information is attached  
 (Please do not staple additional information)

For Health Plan Use Only

TRACKING NUMBER  
PROVIDER ID#