



### 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..
- For routine follow-up, please use the Provider Tracking Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Molina Healthcare of California  
P.O. Box 22722  
Long Beach, CA 90801  
ATTN: Provider Dispute Resolution

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / Medicare ID #:</b>
<b>PROVIDER ADDRESS:</b>	

**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:*\_\_\_\_

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

#### DISPUTE TYPE

- |  |  |
|--|--|
| <input type="checkbox"/> Claim   | <input type="checkbox"/> Seeking Resolution Of A Billing Determination |
| <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision | <input type="checkbox"/> Contract Dispute                              |
| <input type="checkbox"/> Request For Reimbursement Of Overpayment                      | <input type="checkbox"/> Other:  |

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

_____	_____	(    ) _____
<b>Contact Name (please print)</b>	<b>Title</b>	<b>Phone Number</b>
_____	_____	(    ) _____
<b>Signature</b>	<b>Date</b>	<b>Fax Number</b>

<b><i>For Health Plan Use Only</i></b>
TRACKING NUMBER
PROVIDER ID#

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED  
(Please do not staple additional information)