CenCal HEALTH
Local. Quality. Healthcare.

PROVIDER *DISPUTE/APPEAL* RESOLUTION REQUEST

*CONTACT FULL NAME/ADDRESS/PHONE NUMBER

*PROVIDER NPI NO.

***CLAIM TYPE:**
(1) PHARMACY ☐
(2) PHYSICIAN ☐
(3) HOSPITAL INPATIENT ☐
(4) HOSPITAL OUTPATIENT ☐
(5) LTC ☐
(6) VISION ☐
(7) ALLIED/DME ☐

*RESOLUTION REQUEST TYPE ☐ DISPUTE ☐ APPEAL

INSTRUCTIONS:
- Please complete this form if you are seeking reconsideration of a previous claims determination.
- **Dispute** request is for reconsideration of the original claim that has been previously denied and underpaid.
- **Appeal** request is for reconsideration of previously disputed claim(s) that was rejected , denied or underpaid.
- Fields with an asterisk (*) are required. Please provide the Contacts full information or the resolution letter will be mailed to the address on file.
- Multiple "LIKE" Claims are for Disputes ONLY, and to be used for same provider but different members and dates of service.
- Be specific when completing the Description of Dispute/Appeal and Expected Outcome.

*CLAIM INFORMATION ☐ SINGLE ☐ MULTIPLE "LIKE" CLAIMS

*REASON FOR DISPUTE/APPEAL (ENCLOSE ALL SUPPORTING DOCUMENTS. INCLUDING CLAIM COPY.)

*EXPECTED OUTCOME:

*PATIENT NAME:	*ID NUMBER:	*CCN NUMBER:	*DATE OF SERVICE:

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE AND COMPLETE.

SIGNATURE

DATE