Trusted
SENIOR CARE ADVANTAGE

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.
- Mail the completed form to:

  CORE Care Select
  Attn: PDR
  P.O. Box 70033
  Anaheim, CA 92825

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

PROVIDER TYPE ☐MD ☐Mental Health Professional ☐ Mental Health Institutional ☐ 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

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management
☐Decision Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing
☐Determination Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print) | **Title** | **Phone Number**

Signature | **Date** | **(Fax #)**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple)
ICE Approved 10/5/07, effective 1/1/08

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