Scripps

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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Scripps Health Plan, P.O. Box 1928 4S-300, La Jolla, CA 92038
- Or Fax to: 858-260-5878

*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:

* Member 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 Number

[ ] **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 _____

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For use with multiple "LIKE" claims (claims disputed for the same reason)
Please complete the below form. Fields with an asterisk (*) are required.

	* Member Name		* Date of Birth	* Health Plan ID Number	* Original Claim ID Number	* Service From/To Date	* Original Claim Amount Billed	* Original Claim Amount Paid
	* Last	* First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

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

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