PROVIDER DISPUTE RESOLUTION REQUEST

- For routine follow-up, please contact Health Plan of San Mateo's Claims Department at **650-616-2056**.
- To request dispute resolution, please complete the form below. **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.
- You do not need to include a copy of a claim that was previously processed.
- Fax the front and the back of the completed form to **650-829-2051** or mail it to:

Attn: Provider Disputes
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

By submitting this form, I agree not to bill the member(s) named on it. Initial here and sign at bottom of form: ☐

*Provider Name: NPI:

Address:

Provider Type: ☐ PCP ☐ Specialist ☐ Dental ☐ Home Health ☐ ASC ☐ SNF ☐ DME
☐ Hospital ☐ Rehab ☐ Ambulance ☐ Other, please specify:

Line of Business: ☐ CareAdvantage ☐ Medi-Cal ☐ ACE ☐ HealthWorx | ☐ Contracted ☐ Non-Contracted
(See back of form, for CareAdvantage only)

CLAIM INFORMATION

** Required for Claim, Billing, and Reimbursement of Overpayment Disputes*

○ Single Claim ○ Multiple "like" claims (add Supplemental Form) Total #:

*Member Name: DOB:

*Member ID #: Original Claim ID(s):

Service Dates from to Amount Billed: Amount Paid:

Type of Dispute: ☐ Underpayment of a Claim ☐ Request for Reimbursement of Overpayment
☐ Denied Claim ☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Contract Dispute ☐ Other, please specify:

*Description of Dispute

Expected Outcome

☐ Check here if additional information is attached. (Please do not staple.)

Contact Name: Phone:

Contact Title: Fax:

Signature Date

FOR HEALTH PLAN USE ONLY: TRACKING #: PROVIDER ID #:

☐ I am NOT a CareAdvantage Contracted Provider. (Please complete and sign the waiver below.)

☐ I am a Contracted Provider. (Please disregard the waiver.)

Health Plan of San Mateo

Waiver of Liability Statement

Member Name _____ Member ID / Member HIC Number _____

Provider Name _____ Dates of Service _____

Health Plan of San Mateo

Health Plan

As a provider of the mentioned member(s), I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature _____ Date _____

H542_CA_3070_08 (approved 02/08/2008)

Description of Dispute (continued from page 1)

PRINT FORM

FOR HEALTH PLAN USE ONLY: TRACKING #: PROVIDER ID #: