

# 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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Key Medical Group, Inc  
3335 S. Fairway Visalia, CA 93277
- Or by fax: (559) 734-6203

<b>*PROVIDER NPI:</b>	<b>PROVIDER TAX ID:</b>
<b>*PROVIDER NAME:</b>	
<b>PROVIDER ADDRESS:</b>	

**PROVIDER TYPE**     MD     Mental Health Professional     Mental Health Institutional     Hospital     ASC  
 SNF     DME     Rehab     Home Health     Ambulance     Other \_\_\_\_\_  
(please specify type of "other")

<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>	
<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>

<b>DISPUTE TYPE</b>	
<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"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

<b>* DESCRIPTION OF DISPUTE:</b>
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<b>EXPECTED OUTCOME:</b>
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<b>Contact Name (please print)</b>	<b>Title</b>	<b>Phone Number</b>
<b>Signature</b>	<b>Date</b>	<b>Fax Number</b>

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

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