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: Perlman Medical Group
  Attn: Provider Dispute Department
  3900 5th Ave, Ste 200
  San Diego, CA 92103

PRODUCT TYPE:		COMMERCIAL		MEDI-CAL		MEDICARE

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

PROVIDER TYPE:					
	MD		ASC		Rehab
	Mental Health Professional		SNF		Home Health
	Mental Health Institutional		DME		Ambulance
	Hospital		Other, specify		

CLAIM INFORMATION:		Single		Multiple	Number of Claims	
"LIKE" Claims (complete attached spreadsheet)						
CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)						

* 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:	

COMMERCIAL AND MEDI-CAL DISPUTE TYPE:			
	Claim		Downcoding / Payment
	Appeal of Medical Necessity/Utilization Management Decision		Seeking Resolution of a Billing Determination
	Contract Dispute		Other, Specify
	Disputing Request For Reimbursement of Overpayment		
MEDICARE DISPUTE TYPE:			
	Medicare Fee Schedule Payment Dispute		
* DESCRIPTION OF DISPUTE:			
EXPECTED OUTCOME:			

Contact Name (please print)	Title	Phone Number
Signature	Date	Fax Number

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

ICE Approved 10/5/07, effective 1/1/08, revised 2014, revised 2/24/22

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For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient 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								
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