Dental Health Services

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below required form fields with an asterisk **(*)**.
- 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.
- Mail the completed form to:

ATTN: **Operations Manager**
Dental Health Services
3780 Kilroy Airport Way
Suite 750
Long Beach Ca 90806

**You may fill out electronically, print and mail. Open as a PDF and click "fill and sign" on the right navigation.

***PROVIDER NAME:**	***PROVIDER TAX ID #**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ General Dentist ☐ Specialist

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:_

* **Patient Name:**		**Date of Birth:**
* **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 Number** (   ) ____________

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

For Health Plan/RBO Use Only
TRACKING NUMBER____________________PROV ID# ___________
CONTRACTED_____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

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

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