# 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: California Provider Dispute Resolution Request

| Cigna Network | GWH - Cigna Network |
|---|---|
| P.O. Box 188011 | P.O. Box 668 |
| Chattanooga, TN 37422 | Kennett, MO 63857 |

*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): ______________________

CLAIM INFORMATION:

☐ Single ☐ Multiple **"LIKE"** Claims (Complete attached spreadsheet) Number of Claims: ________

*Patient Last Name | (First) | (MI) | Date of Birth

*Health Plan ID Number | Patient Account Number | Original Claim ID Number (If multiple claims, use attached spreadsheet)

*Service Dates: (Required for Claim, Billing and Reimbursement of Overpayment Disputes) From: ________ To: ________ | 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 ____

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