brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: **Brand New Day**
  Provider Appeals Department
  P.O. Box 93122
  Long Beach, Ca 90809-6547

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

PROVIDER TYPE

☐ MD ☐ MENTAL HEALTH ☐ HOSPITAL ☐ ASC ☐ SNF ☐ DME ☐ REHAB
☐ HOME HEALTH ☐ AMBULANCE ☐ OTHER_____
(Please specify type of "other")

CLAIM INFORMATION

☐ Single ☐ Multiple " LIKE" Claims (complete attached spreadsheet) Number of claims: _____

Patient Name:		Date of Birth:	
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: *(for multiple "like" claims attach 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
☐ 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