Physicians Medical Group of San Jose

EXCEL MSO, LLC

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. Include a copy of a claim that is being disputed.
- For routine follow-up, please use the **Claims Follow-Up/Inquiry Form** instead of this form.
- Mail the completed form to: **Physicians Medical Group of San Jose** – Provider Appeals
  75 E. Santa Clara St. Suite 950
  San Jose, CA 95113

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

PROVIDER TYPE ☐ MD ☐ Lab / X-ray ☐ Mental Health ☐ Hospital ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

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

* 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:

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

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

J:\AB1455\Forms\Provider Disputes Resolution Request Form 5/6/05

For PMG Use Only
TRACKING NUMBER
PROVIDER ID#

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

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Number	* 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	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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

PROVIDER DISPUTE RESOLUTION REQUEST FORM
INFORMATION SUPPLEMENT
Physicians Medical Group of San Jose

What is a Provider Dispute?

A provider dispute is a written notice from a provider that challenges, appeals, or requests consideration in any of the following categories:

- **Claim** (including a bundled group of similar claims) that were previously denied, adjusted or contested
- **Billing Determination**
- **Appeal of Medical Necessity** (Appeal of a Clinical Decision)
- **Utilization Management Decision** (e.g. Appeal of an Administrative Decision such as Eligibility or Benefit Coverage)
- **Request For Reimbursement of Overpayment**
- **Contract Dispute** or other billing determination
- Any **Other** category of dispute that does not fall into any of the above categories

To submit a provider dispute, complete the attached form. Check the appropriate **category** under **DISPUTE TYPE** when submitting this form to Physicians Medical Group of San Jose. Disputes must include:

- Provider's Name / ID Number
- Contact information including phone number
- The number assigned to the original claim (on the EOB)

Unless required by any state or federal law or regulation, **provider disputes must be received within 365 days** from denial or payment determination or in the case of inaction, within 365 days of the time for contesting or denying claims.

Can a Dispute be submitted by the Provider on a member's behalf?

Any Disputes submitted on behalf of a member are processed through the member appeal process, as long as the member has authorized the provider to appeal on their behalf.

Members have the right to authorize a representative to act on their behalf at any level of the grievance/appeal process. A signed authorization is not required if the grievance/appeal is submitted by he parent, guardian, conservator, relative or other designee (Provider) of the member if the member is a minor, or incompetent or incapacitated.