# PROVIDER DISPUTE RESOLUTION REQUEST NV

**IMPERIAL INSURANCE COMPANIES**

P.O. Box 60590

Pasadena, CA 91116

Mail the completed form to**:**

**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.

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| --- | --- |
| **\*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 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:** (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 Seeking Resolution of A Billing Determination  Appeal of Medical Necessity / Utilization Management Decision Contract Dispute Disputing Request for Reimbursement of Overpayment Other: | | | | | |

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

## Contact Name (please print) Title Phone Number

**( )**

## Signature Date Fax Number

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

*For Health Plan/RBO Use Only*

TRACKING NUMBER PROV ID#

CONTRACTED NON-CONTRACTED

# PROVIDER DISPUTE RESOLUTION REQUEST

**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** |
| **Last** | **First** |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |
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| 10 |  |  |  |  |  |  |
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| 12 |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |

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[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

(Please do not staple)

ICE Approved 11/1/22, effective 1/1/24