



Community Health Plan OF IMPERIAL VALLEY | ADVANTAGE PLUS

PROVIDER DISPUTE RESOLUTION (PDR) REQUEST

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

- Please complete the form below. All fields marked with an asterisk (*) are required.
- Be specific when filling out the DESCRIPTION OF DISPUTE/EXPLANATION & EXPECTED OUTCOME sections.
- Provide additional information to support your dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims refer to similar disputes from the same provider but involve different members and dates of service.
- Mail this completed form to: **Community Health Plan of Imperial Valley**
Attention: Provider Services #29
P.O. Box 210700
Chula Vista CA 91921

***PROVIDER NPI:**

***PROVIDER TAX ID:**

***PROVIDER NAME:**

PROVIDER ADDRESS: (Indicate below where to mail PDR correspondence)

***EMAIL ADDRESS:**

FAX:

PROVIDER TYPE: ☐ MD/PCP ☐ Specialist (Type: _____) ☐ Mental Health Professional ☐ Mental Health Institution
☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____

Please Specify

CLAIM INFORMATION: ☐ Single ☐ Multiple "LIKE" Claims *Number of claims:* _____

***PATIENT NAME:**

***DATE OF BIRTH:**

***CHPIV ID:**

PATIENT ACCOUNT NUMBER:

ORIGINAL CLAIM ID NUMBER:

(If multiple claims, attach spreadsheet)

***SERVICE DATE(S):**

ORIGINAL CLAIM AMOUNT BILLED:

ORIGINAL CLAIM AMOUNT PAID:

***DISPUTE TYPE:**

☐ Claim Denial ☐ Claim Underpayment ☐ Other: _____

☐ Contract Dispute ☐ Disputing Request for Reimbursement of Overpayment

Please explain

☐ PDR to appeal for Medical Necessity. Please check this box if you received a Notice of Action denial letter from our Utilization Management (UM) Department and you would like to appeal the denial for medical necessity. *Complete the next section.*

FILL OUT THIS SECTION TO REQUEST A PDR FOR MEDICAL NECESSITY REVIEW:

Please check one: ☐ Prior Authorization ☐ Concurrent Review Authorization reference number: _____

Requested service: _____ Have these services been rendered? ☐ Yes ☐ No

Place of service: _____ Date(s) of service: _____

Make sure to:

- Attach a copy of the NOA Denial Letter
- Attach any supporting clinical documentation; **NOTE: Please only send clinical records that are pertinent for the DOS you are contesting.**
- Provide a clear explanation as to why the denial decision should be overturned in the space provided below.

***DESCRIPTION OF DISPUTE/EXPLANATION:**

***EXPECTED OUTCOME:**

Contact Name and Title (print)

Signature/Date

Phone#