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
  P.O. Box 174
  Imperial, CA 92251-9834

***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#