HUMBOLDT IPA PROVIDER DISPUTE RESOLUTION REQUEST FORM

Submission of this form constitutes agreement not to bill the patient during the dispute resolution process.

INSTRUCTIONS

- For routine claim status, please visit our website, portal.humboldtipa.com.
- For other claim review requests, please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE.
- Provide additional information to support the description of the dispute. Please only provide information related to the procedure billed and no more than 1 year prior to the date of service on the claim. **DISPUTES RECEIVED WITH NO ADDITIONAL INFORMATION WILL NOT BE CONSIDERED FOR REVIEW.**
- Send the completed form by mail to The Humboldt IPA, 2315 Dean Street, Eureka, CA 95501 or by fax to (707) 442-2047.
- PDR status can be obtained on our website, portal.humboldtipa.com.

***PROVIDER NAME:**_____ ***PROVIDER TAX ID #:**_____

*** Patient Name:**			**Date of Birth:**
*** Health Plan Name** *** Health Plan ID Number:**	**Patient Account Number:**	***Original Claim ID Number:**	
***Service "From/To" Date**	***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:**

_____ ***Contact Name (please print)**

_____ **Title**

(____)_____ ***Phone Number**

(____)_____ ***Fax Number**