

# PROVIDER DISPUTE RESOLUTION REQUEST

## 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.
- For routine follow-up status, instead of the Provider Dispute Resolution Form, please utilize our online web portal, located at <https://portal.ppmcinc.com/Login.aspx>, or fax your status request to (951) 280-8206.
- Mail or fax the completed form to:
 

Vantage Medical Group  
 2115 Compton Avenue, Dept. 300  
 Corona, CA 92881  
 Fax: (951) 280-8206

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / Medicare ID #:</b>
<b>PROVIDER ADDRESS:</b>	

**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:* \_\_\_\_\_

<b>* Patient Name:</b>		<b>Date of Birth:</b>	
<b>* Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)	
<b>Service "From/To" Date:</b> ( * Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)		<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>

**DISPUTE TYPE**

<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

<b>Contact Name (please print)</b>	<b>Title</b>	(    )
<b>Signature</b>	<b>Date</b>	(    )
		<b>Phone Number</b>
		<b>Fax Number</b>

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

*For Health Plan/RBO Use Only*

TRACKING NUMBER \_\_\_\_\_ PROV ID# \_\_\_\_\_

CONTRACTED \_\_\_\_\_ NON-CONTRACTED \_\_\_\_\_

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

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									
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14									
15									

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