



PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

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

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.
- Mail the completed form to: Claims Department – Kern Family Health Care
9700 Stockdale Hwy
Bakersfield, CA 93311

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE MD Mental Health 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 Document Number: (If multiple claims, use attached spreadsheet)	
*Service "From/To" Date:		Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE: **First Level** _____ **Second Level** _____

Claim Seeking Resolution Of A Billing Determination

Appeal of Medical Necessity / Utilization Management Decision

Request For Reimbursement Of Overpayment

*** DESCRIPTION OF DISPUTE** (must include a clear explanation of the basis upon which you believe KHS' action is incorrect):

EXPECTED OUTCOME:

_____	_____	_____
*Contact Name (please print)	Title	() *Phone Number
_____	_____	_____
Signature	Date	() *Fax Number

Kern Family Health Care received this dispute on _____. If you have not received a response to this dispute within 45 working days, please call the Claims Department at (800) 391-2000.

_____ (signature)
Acknowledgement of Receipt

