Valley Health Plan

# Provider Dispute Form

Claims, Medical, and Administrative Disputes
Phone: 1.408.885.7380 Option 4

**Providers may complete this form to dispute a VHP claim denial.** **Date:** _____

- Fields with an asterisk (*) are required for processing. Disputes with required fields missing may be returned.
- Provider should specify and attach any additional information or documentation to support the description of the dispute.
- For multiple "Like" disputes please complete and include the Multiple Like Dispute Form.
- This form can be mailed to:

  Valley Health Plan, Provider Dispute Resolution, P.O. Box 28387, San Jose, CA 95159
- If provider is appealing a denied authorization on behalf of the member, please contact Member Services Department at **1.888.421.8444**.
- For reconsiderations or retro-authorization requests, please contact Utilization Management Department at **1.408.885.4647**.
- If the claim is denied and VHP is requesting additional information, please submit a corrected claim with the additional information to the Claims Department.
- For routine claim follow-up status, instead of submitting a dispute, please call VHP at **1.408.885.4563**.

## Provider Information:

| *Provider NPI: | *Provider Tax ID: |
|---|---|
| *Provider Name: | |
| *Provider Address: | |

**Provider Type:** ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other: _____

**Dispute Type:**
☐ Claim (Underpayment/Timely Filing/EOB, etc.) ☐ Contract
☐ Appeal of Medical Necessity / Utilization Management Decision (*Authorization # _____ )
☐ Dispute of a Refund (request for reimbursement of overpayment)
☐ Other: _____

**Claim Information:** ☐ Single ☐ Multiple (*Fill out Multiple Like Dispute Form)

| *Patient Name: | *Date of Birth: |
|---|---|
| *Member ID #: | Patient Account #: |
| *VHP Claim #: | *Date of Service: |
| *Original Claim Amount Billed: | Original Claim Amount Paid: |

***Dispute Description** (Please refer to Page 2 if additional space is required)**:**

**Attachments:**
☐ Medical Records ☐ Authorization / Referral ☐ COB / EOB
☐ Proof of Timely Filing ☐ Proof of Eligibility ☐ AOR
☐ Invoice / Bill ☐ Other: _____

**Expected Outcome** (Please refer to Page 2 if additional space is required)**:**

## Contact Information:

*Contact Name: _____ Title: _____ Phone Number: _____
*Signature: _____ Date: _____ *Fax Number: _____
*Mailing Address: _____
*Email: _____

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**Claim Information:**

| *Patient Name: | *Date of Birth: |
|---|---|
| *Member ID #: | Patient Account Number: |
| *VHP Claim #: | *Date of Service: |
| *Original Claim Amount Billed: | Original Claim Amount Paid: |

**Dispute Description (cont.):**

**Expected Outcome (cont.):**

*Contact Name: _____ Title: _____ Phone Number: _____

*Signature: _____ Date: _____ *Fax Number: _____

*Mailing Address: _____

*Email: _____

Valley Health Plan

# Provider Dispute Form

For Use with Multiple "LIKE" Claims
Phone: 1.408.885.7380 Option 4

**Date:** _____

Multiple "LIKE" claims are for the same provider and dispute type but different members. Fields with an asterisk (*) are required. If filing multiple "LIKE" claims please complete all pages of the Provider Dispute Form and mail to: VHP, Provider Dispute Resolution, P.O. Box 28387, San Jose, CA 95159.

*Provider Name: _____ *NPI Number: _____

*Provider Address: _____

| | *Patient Name | | *Date of Birth | *Health Plan ID Number | *Original Claim Number | *Date of Service | *Original Claim Amount Billed | Original Claim Amount Paid |
|---|---|---|---|---|---|---|---|---|
| | Last | First | | | | | | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| | | | | | | | | |

*Contact Name: _____ Title: _____ Phone Number: _____

*Signature: _____ Date: _____ *Fax Number: _____

*Mailing Address: _____

*Email: _____