CenCal HEALTH®
Local. Quality. Healthcare.

PROVIDER DISPUTE/APPEAL RESOLUTION REQUEST

ADDRESS TO WHICH RESPONSE SHOULD BE SENT:	PROVIDER NPI:	CLAIM TYPE:
_____ _____ _____ _____	_____	(1) Pharmacy ☐ (2) Physician ☐ (3) Hospital Inpatient ☐ (4) Hospital Outpatient ☐ (5) LTC ☐ (6) Vision ☐ (7) Allied/DME ☐

RESOLUTION REQUEST TYPE: ☐ DISPUTE ☐ APPEAL

INSTRUCTIONS:
- Fields with an asterisk (*) are required. Please provide the Contact's full information, or the resolution letter will be mailed to the address on file.
- Please complete this form if you are seeking reconsideration of a previous claims determination.
- Dispute request is for reconsideration of the original claim that has been previously denied and underpaid.
- Appeal request is for reconsideration of previously disputed claim(s) that was rejected, denied or underpaid.
- Multiple "LIKE" Claims are for Disputes ONLY, and to be used for same provider but different members and dates of service.
- Be specific when completing the Description of Dispute/Appeal and Expected Outcome.

CLAIM INFORMATION: ☐ SINGLE ☐ MULTIPLE "LIKE" CLAIMS

REASON FOR DISPUTE/APPEAL (Enclose all supporting documents, including claim copy):

EXPECTED OUTCOME:

PATIENT NAME:	MEMBER ID NUMBER:	CLAIM CONTROL NUMBER (CCN):	DATE OF SERVICE:

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE.

_____ _____
SIGNATURE DATE

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