

MPMG PROVIDER DISPUTE RESOLUTION REQUEST FORM

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

INSTRUCTIONS

- Please complete the form below. 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 standard questions and claims adjustments, you may call MPMG Customer Service at 650-240-8059.**
- Mail the completed form to:
 - MPMG Provider Dispute Unit
 - P. O. Box 4348
 - Burlingame, CA 94010-4348
- Fax the completed form to: 650-240-0900

*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 ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

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

* **DESCRIPTION OF DISPUTE** (Please attach additional information as needed):

EXPECTED OUTCOME:

Contact Name (please print)	Title	() Phone Number
Signature of Disputing Party	Date	() Fax Number

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 (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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CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
 (Please do not staple additional information)