Provider Claims Dispute Request Form

This form is for all providers disputing a claim with CalOptima Health. For additional information and requirements regarding provider claim disputes, please refer to Policies HH.1101, MA.9006 and MA.9009 found under the Providers section of www.caloptima.org.

Please return this completed form and any supporting documentation to CalOptima Health by mailing them to:

Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

PLEASE NOTE:

This form is for claim payment disputes related to reimbursement rates or processing. This form is **NOT** intended for requests related to clinical reviews for medical necessity determinations in the case of a denied authorization or retrospective review request. A separate form must be completed for each member, and all information must be included, i.e., claim number, member client index number (CIN) and date of service.

To request a service authorization dispute (medical necessity) please complete the provider service authorization dispute request form, which can be found at www.caloptima.org.

For routine follow-up regarding **claims or PDR status**, please contact the CalOptima Health Claims Provider Line at **714-246-8600**.

PROVIDER QUESTIONNAIRE

1) Have you received a payment remittance (paper or electronic) for this claim? ☐ YES ☐ NO
2) If you answered "NO" to question 1, please call the appropriate network to check on the claim status.
3) If you answered "YES" to question 1, are you disputing the outcome of the claim adjudication or the payment dispute?

   ☐ Claims adjudication ☐ Payment dispute
4) If you answered "Claims adjudication" to question 3 and the health network is not CalOptima Health Community Network (CCN) or CalOptima Health Direct (COD), please **do not** complete this form. You must submit a payment dispute to the appropriate health network prior to submitting your request to CalOptima Health. If you answered, "Payment dispute," please include the Level 1 decision and complete this form. If the health network is CCN or COD, please complete this form.
5) Please check the application box below:

   ☐ Contracted provider ☐ Non-contracted provider (Waiver of Liability [WOL] required for OneCare)

Please select the applicable health network below:

☐ AltaMed Health Services	☐ Kaiser Permanente
☐ AMVI Care Medical Group	☐ Noble Mid-Orange County
☐ CHOC Health Alliance	☐ Prospect Medical Group
☐ CCN or COD	☐ Optum Care Network
☐ Family Choice Health Services	☐ United Medical Care Group
☐ Family Choice Medical Group	☐ Vision Services Plan (VSP)
☐ HPN – Regal Medical Group	

SECTION 1: Claim Dispute

Processing Time: 45 Business Days

Claim/EDI Tracking Number(s):		Member ID #:	
Member Name		Date(s) of Service:	
Provider Name:		Billed Charges:	Contact Person:
Provider ID (TIN):	NPI:	Provider Phone #: ( )	Provider Fax #: ( )

Type of Claim Dispute

Based upon the following reasons, the provider requests reconsideration of this claim.
Providers: Please check applicable reasons and attach all supporting documentation.

☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/tax ID
☐ **Coding/Bundling Edits:** Attach supporting documentation/medical records (Documentation is required)	☐ **Timely Filing:** Attach claims and supporting documentation showing claim was filed in a timely manner
☐ **Coordination of Benefits Information:** COB–related adjustment primary insurance	☐ **Payment Amount:** _____
	☐ **Claims Reversal Needed:** Reason: _____
☐ **Service Is Not a Duplicate:** Rationale (Documentation is required):	☐ **Under/Overpayment:** Rationale (Documentation is required):
☐ **Authorization Approved:** Include Notice of Approval (NOA) or other notification of approval.	**Comment/Other:**