health net

BEHAVIORAL HEALTH PROVIDER DISPUTE RESOLUTION REQUEST

For Medicare ONLY Mail to:
Provider Appeals/Dispute
P.O. BOX 9030
Farmington, MO
63640-9030

For Marketplace ONLY Mail to: :
Provider Appeals/Dispute
P.O. BOX 9040
Farmington, MO
63640-9040

For all other Products Mail to:
Provider Appeals/Dispute
P.O. BOX 989882
West Sacramento, CA
95798-9882

INSTRUCTIONS

- Please complete the form below. Fields with an asterisk (*) are always required.
- Fields with a double asterisk (**) are required for Claim, Billing and Reimbursement of Overpayment Disputes.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.

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

PROVIDER TYPE ☐ MD/DO ☐ 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:**
*** Subscriber ID Number:**	**Patient ID Number:**	****Original Claim Form ID Number: (If multiple claims, attach Multiple Claim Spreadsheet)**

****Service "From/To" Date:**	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request for Reimbursement of Overpayment
☐ Seeking Resolution of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

*** EXPECTED OUTCOME:**

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

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

For Behavioral Health Use Only
TRACKING NUMBER PROVIDER ID#