CLAIMS RESUBMISSIOM FORM

(ATTACH ONE FORM PER CLAIM)

INSTRUCTIONS

- This form is for routine follow-up and/or submission of additional information needed to process your claim. Should you want to initiate the formal dispute process, you will need to complete the "Provider Dispute Resolution Form" which can be accessed through the Riverside Medical Clinic web site.
    - Mail the completed form and all supporting documentation to:

Riverside Medical Clinic
Attn: Prepaid Dept. Claims Unit
3660 Arlington Ave.
Riverside, CA. 92506

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

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Hospital ☐ ASC ☐ SNF ☐ Rehab

CONTRACTED Y / N **CLAIM INFORMATION**

*** Patient Name:**		**Date of Birth:**
Billing Office Contact Name/Title:	**Contact Telephone Number:**	**Original Claim Number:**
Service "From/To" Date:	**HMO Name:**	**Commercial or Senior Plan**

INSTRUCTIONS: When submitting this form with additional information, please attach the proper documentation including a copy of any documentation received from RMC or the health plan. Shaded boxes indicate required fields.

REASON FOR RESUBMISSION: Check all that apply:

COB/Medicare information attached
Corrected Claims (i.e, ICD.9, CPT, HCPC, Modifier, etc)
EOB or EOMB of Primary Insurance Carrier attached
Hard Copy of Itemized Claim
Medical Records
Physician Progress Notes
Proof of Authorization
Request for Additional Payment
Additional Charges
Other_____

_____

Please provide a detailed explanation of the issue: _____
_____
_____
_____

PROVIDER DISPUTE RESOLUTION REQUEST
(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									
13									
14									
15									

RMC Document Revised 02/13/07

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	**PROVIDER ID#:**
a. PROVIDER NAME:	**b. CONTRACTED PROVIDER: _____ YES _____ NO**
c. DATE DISPUTE RECEIVED (Date Stamped):	**d. DATE OF INITIAL PAYMENT OR ACTION:**
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____ NO (If NO, should be returned to provider without action)	
f.1. DISPUTE TYPE: ☐ CLAIM ISSUE ☐ OVERPAYMENT REIMBURSEMENT REQUEST ☐ BILLING ISSUE ☐ CONTRACT ISSUE ☐ UM/MEDICAL NECESSITY ISSUE ☐ OTHER _____ (Please specify type of "other")	
f.2. PROVIDER TYPE: ☐ PROFESSIONAL ☐ INSTITUTIONAL	
g. DATE DISPUTE ACKNOWLEDGED:	**h. TURNAROUND TIME (g – c):**

TYPE OF LETTER SENT: **(List the various ICE letters as applicable)**

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	**k. ACTION TURNAROUND TIME (j – c):**	**l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):**

IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	**n. TURNAROUND TIME (m – c):**	
o. DATE ADDITIONAL INFO RECEIVED:	**p. RECEIPT TURNAROUND TIME (o – m):**	
q. DATE OF ACTION:	**r. ACTION TURNAROUND TIME (q – o):**	**s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):**

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE: