



# PROVIDER DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims)



Legendary Care™

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									

# PROVIDER DISPUTE RESOLUTION REQUEST

## Tracking Form

(For Optional Use by Health Plan/Delegated Provider)



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### 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.

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

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

### **IF NO ADDITIONAL INFORMATION REQUESTED:**

<b>j. DATE OF ACTION:</b>	<b>k. ACTION TURNAROUND TIME (j – c):</b>	<b>l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):</b>
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### **IF ADDITIONAL INFORMATION REQUESTED:**

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

<b>COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:</b>
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