VENTURA COUNTY
HEALTH CARE PLAN

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. 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.

Mail the completed form to the following address:

VCHCP Provider Appeals Unit 2220 E. Gonzalez Rd., Ste. 210B, Oxnard, CA 93036

For provider dispute inquiries or filing information, please contact us at (805) 981-5050, (800) 600-8247, or go to our website: www.vchealthcareplan.org

* PROVIDER NAME:	*TAX ID #:
*ADDRESS:	Contracted: Y / N

PROVIDER TYPE: ( ) Physician ( ) Mental Health ( ) Hospital ( ) ASC/ Outpatient Services ( ) SNF ( ) DME ( ) Rehab ( ) Home Health ( ) Ambulance ( ) Other Professional (please specify type of "other") _____

*** CLAIM INFORMATION** ( ) Single ( ) Multiple "**LIKE"** Claims (complete attached spreadsheet) *Number of claims*:_____

* Patient Name:		Date of Birth:
* Social Security Number:	* Subscriber ID #:	* Original Claim ID #:
* Service "From / To" Date:	Original Claim Amount Billed:	Original Claim Amount Paid

Dispute Type: ( ) Claim ( ) Appeal of Medical Necessity / Utilization Management Decision ( ) Contract Dispute ( ) Seeking Resolution of a Billing Determination ( ) Disputing a Request for Reimbursement of Overpayment ( ) Other

*** DESCRIPTION OF DISPUTE: Indicate reason for dispute, provider's position and basis therefore:** (Additional paper may be attached if necessary)

*** EXPECTED OUTCOME:** (please provide by claim if multiple)

Contact Name (please print)	Title	Area Code & Phone Number
Signature and Date	Email Address	Area Code & Fax Number

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

For Health Plan Use Only:
Case #_____
Provider #_____

VENTURA COUNTY
HEALTH CARE PLAN

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS: (For use with multiple "Like" claims only)

- Please complete the below form. 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.
- Mail completed form to the following address: VCHCP Provider Appeals Unit
  2220 E. Gonzalez Rd., #210-B
  Oxnard, CA 93036
  (805) 981-5050 or (800) 600-8247 or go to our website: www.vchealthcareplan.org

For provider dispute inquiries or filing information, please contact us at the phone number listed above.

Number	*Patient Name		*Subscriber ID No./CIN 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.								

( ) CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

(Please do not staple additional information) Updated/Reviewed August, 2011, 2012, 2013, 2014, 2016, 2/2018

For Health Plan Use Only:
Case #_____
Provider #_____