



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. Gonzales Rd., Ste. 210B, Oxnard, CA 93036

For provider dispute inquiries or filing information, please contact us at (805) 981-5050,

toll free at (800) 600-8247, or visit our website: vchcp.venturacounty.gov

* 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)

Page 1 of 2

For Health Plan Use Only:

Case # _____

Provider # _____



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. Gonzales Rd., #210B
Oxnard, CA 93036

For provider dispute inquiries or filing information, please contact us at (805) 981-5050, toll free at (800) 600-8247 or visit our website: vchcp.venturacounty.gov

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

Page 2 of 2

(Please do not staple additional information) Updated/Reviewed August, 2011, 2012, 2013, 2014, 2016, 2/2018, 10/2025

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