Provider Dispute Resolution (PDR) Request

Instructions: Please complete the below form. ***Fields with an asterisk (*) are required.*** Be specific when completing the DESCRIPTION OF THE DISPUTE AND EXPECTED OUTCOME. ***Do not use this form if submitting corrections.*** Do not include a copy of a claim that was previously processed. Provide additional information to support the description of the dispute.

How to Submit:

The preferred and most efficient method is **via FAX: 562-997-1835**
By mail, send to: SCAN Health Plan, Attn: DCR-Provider Disputes, PO BOX 22698, Long Beach, CA 90801

PROVIDER INFORMATION:

***Provider Name:**

Provider Address:

Street Address City Zip Code

***Tax ID#:** ***NPI#:**

Check if Provider: Contracted Provider / Non Contracted Provider

CLAIM INFORMATION:

***Member Name:**

Date of Birth (MM/DD/YYYY):

***Member ID#:**

***Member Acct#:**

Procedure Codes:

Scan Claim #:

***Service From Date** (MM/DD/YYYY):

***Service To Date** (MM/DD/YYYY):

***Original Claim Amount Billed:**

Claim Amount Paid:

Expected Additional Payment:

DISPUTE TYPE:

- CONTRACTED UNDERPAYMENT
- CONTRACTED RETRO AUTHORIZATION REQUEST
- CONTRACTED AUTHORIZATION DENIAL
- CONTRACTED SEEKING RESOLUTION OF A BILLING DETERMINATION
- DISPUTING REQUEST FOR REIMBURSEMENT OF AN OVERPAYMENT
- NON CONTRACTED 1st LEVEL PAYMENT DISPUTE
- NON CONTRACTED 2nd LEVEL PAYMENT DISPUTE
- NON CONTRACTED MEDICAL NECESSITY DENIAL

***DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

***Contact Name** **Title** ***Phone (xxx) xxx-xxxx**

Email ***Date** MM/DD/YYYY ***Fax (xxx) xxx-xxxx**

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