



HEALTH CARE PROFESSIONAL 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.
- Multiple "LIKE" claims are for the same health care professional and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Health Care Professional Dispute Resolution Form.
- Mail the completed form to: California Health Care Professional Dispute Resolution Request

Cigna
PO Box 188011
Chattanooga, TN 37422

If **GWH -Cigna or 'G' is listed on the front of the card:**
PO Box 188062
Chattanooga, TN 37422-8062

*HEALTH CARE PROFESSIONAL NPI:

HEALTH CARE PROFESSIONAL TAX ID:

*HEALTH CARE PROFESSIONAL NAME:

HEALTH CARE PROFESSIONAL ADDRESS:

HEALTH CARE PROFESSIONAL TYPE MD Mental Health Professional Mental Health Institutional
 Hospital ASC SNF DME Rehab Home Health Ambulance
 Other _____ (please specify type of "other")

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

* Patient Name:

Date of Birth:

* Health Plan ID Number:

Patient Account Number:

Original Claim ID Number: (If multiple claims, use attached spreadsheet)

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)

Original Claim Amount Billed:

Original Claim Amount Paid:

DISPUTE TYPE

- Claim Seeking Resolution Of A Billing Determination
 Appeal of Medical Necessity / Utilization Management Decision Contract Dispute
 Disputing Request For Reimbursement Of Overpayment Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print)

Title

Phone Number

Signature

Date

Fax Number

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)
ICE Approved 10/5/07, effective 1/1/08

For Health Plan/RBO Use Only

TRACKING NUMBER _____ PROV ID# _____

CONTRACTED _____ NON-CONTRACTED _____