Blue Shield of California

provider dispute resolution request

Instructions

Provider disputes must be submitted in writing to:

Blue Shield Dispute Resolution Office
P.O. Box 272620
Chico, CA 95927-2620

Provider disputes regarding facility contract exception(s) must be submitted in writing to:

Blue Shield Dispute Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Provider name	**Provider ID** (Blue Shield PIN, provider's tax ID, or SSN)

Contact information (mailing address and phone number)

Claim information ☐ Single ☐ Multiple claims (complete attached worksheet)

Patient name	**Patient date of birth**
Subscriber No.	**Service from/to date**

Dispute type

☐ **BENEFITS**
- ☐ Benefit Coverage
- ☐ Benefits Maximum
- ☐ Member Liability
- ☐ Pre-Existing Condition

☐ **ELIGIBILITY**
- ☐ Ineligible Member with Valid Auth
- ☐ Patient Eligibility
- ☐ Retro-Activation Eligibility

☐ **NON-CLAIM RELATED**
- ☐ Contract Effective Date
- ☐ Provider Eligibility
- ☐ Provider Manual/Other Policy/Terms

☐ **CLINICAL**
- ☐ Blue Shield Medical Policy
- ☐ Length of Stay / Level of Care
- ☐ No Authorization
- ☐ Partial/Insufficient Authorization
- ☐ Valid Authorization on File

☐ **COORDINATION OF BENEFITS (COB)**
- ☐ Blue Shield Secondary Payer
- ☐ COB payment structure

☐ **OVERPAY RECOVERY**
- ☐ Recoupment of Claim Overpayment

☐ **TIMELY SUBMISSION**
- ☐ Timely Filing Limit of Initial/Final Appeal Submission
- ☐ Timely Filing Limit of Claim Submission

☐ **PROFESSIONAL CONTRACTUAL REIMBURSEMENT**

- ☐ ACS/Home Healthcare/Infusion
- ☐ Anesthesia
- ☐Assistant
- ☐ Chemo (Admin/Drugs/Injectables)
- ☐ Diagnostic Testing
- ☐ DME/HME/Supplies
- ☐ Emergency Services
- ☐ Family Planning
- ☐ Fetal Genetic Testing
- ☐ Gould Criteria
- ☐ Immunizations (Adult/Child)
- ☐ Laboratory/Radiology/Ancillary
- ☐ Letter of Agreement / Reasonable & Customary / Continuity of Care
- ☐ Maternity
- ☐ Modifier
- ☐ Office Visit/Consultation
- ☐ Pharmaceuticals/Injections/Drugs
- ☐ Psychiatric/ Substance Abuse
- ☐ Special Pricing
- ☐ Surgery
- ☐ Therapy Services
- ☐ Transplant/Global Period
- ☐ Units of Service

☐ **DIVISION OF FINANCIAL RESPONSIBILITY (DOFR)**

- ☐ Ambulance
- ☐ Blood Transfusions/Products
- ☐ Cancer Clinical Trial
- ☐ Chemotherapy (Admin/Drugs/Injectables)
- ☐ Detox
- ☐ Diagnostic Testing
- ☐ DME/HME/Supplies
- ☐ ER Services (In Area)
- ☐ ER Services (Out of Area)
- ☐ False Labor Check
- ☐ Family Planning
- ☐ Fetal Genetic Testing
- ☐ Fetal Monitoring
- ☐ Immunizations, Adult/Child
- ☐ Infusion
- ☐ Invasive Cardiology/Surgical
- ☐ Lab/Radiology/Ancillary Services
- ☐ Maternity Pre & Post/Delivery
- ☐ Office Visit/Consultation
- ☐ POS Opt-Out
- ☐ Pre Admission Testing
- ☐ Psychiatric/Substance Abuse
- ☐ Renal Dialysis
- ☐ Surgery
- ☐ Therapy Services (PT, OT, RT, ST, Cardiac)
- ☐ Urgent Care (In Area)
- ☐ Urgent Care (Out of Area)

☐ **PROFESSIONAL PAYMENT LOGIC**

- ☐ Age/Gender
- ☐ Assistant
- ☐ CCI Incidental
- ☐ CCI Mutually Exclusive
- ☐ Duplicate
- ☐ Invalid Codes
- ☐ Maximum Daily Allowances
- ☐ Pay Percent Application
- ☐ Pre/Post Operative Visits included in Surgical Charge
- ☐ Rebundling
- ☐ Scope of Licensure

Additional explanation of issue:

☐ Check here if additional information is attached.

If submitting multiple claims (on the next page), please fill in before clicking print button.

Multiple claim information

1	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
2	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
3	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
4	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
5	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
6	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
7	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
8	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
9	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	
10	Last name	First name
	Date of birth	Subscriber No.
	Original claims No. (ICN)	Service from/to date
	Expected outcome	

An Independent Member of the Blue Shield Association C40837-FF (6/10)