



Promise Health Plan

# fax

<b>To:</b>	Recipient Name	<b>From:</b>	Your Name
<b>IPA:</b>		<b>Position:</b>	
<b>Fax:</b>	Fax Number	<b>Pages:</b>	Number of pages
<b>Phone:</b>	Phone Number	<b>Date:</b>	
<b>Re:</b>	Urgent Response 10-Day Letter Request	<b>Response must be received by:</b>	

**Member:**

- Urgent     For Review     Please Comment     Please Reply     Please Recycle

The attached claim(s) on the above reference Blue Shield of California Promise Health Plan member is the responsibility of the member's IPA or Medical Group. For this reason, the claim is being forwarded to you for immediate processing. Please research the enclosed/attached item(s) and **return to Blue Shield of California Promise Health Plan within 10 (TEN) working days from the date on this fax.** The completed request may be sent via fax to Blue Shield of California Promise Health Plan Claims Department at (323) 889 -6639.

If the claim(s) is/are not processed by the time indicated, Blue Shield of California Promise Health Plan shall process the claim(s) after thorough review of the medical necessity. The amount paid on behalf of the IPA/Medical Group/Capitated Hospital in addition, a processing fee will be deducted from your future monthly capitation check.

Any payments made by the IPA/Medical Group/Capitated Hospital subsequent to cap-deduction will create a potential double payment to the provider of service and the duplicate payment recovery will be the responsibility of the IPA/Medical Group/Capitated Hospital. To avoid any possible cap-deduction inconvenience, please be sure that the required information is faxed to Blue Shield of California Promise Health Plan by the due date indicated above.

Please furnish Blue Shield of California Promise Health Plan with the following:

Payment / Denial Information

Processed Date: \_\_\_/\_\_\_/\_\_\_ Amount Paid \$\_\_\_\_\_ Check #: \_\_\_\_\_

Denial Date: \_\_\_/\_\_\_/\_\_\_ Denial Reason: \_\_\_\_\_

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