PROVIDER DISPUTE RESOLUTION REQUEST
Santa Barbara Select IPA

NOTE: Submission of this form constitutes agreement not to bill the patient.

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.
- For routine follow-up, please contact customer service instead of the Provider Dispute Resolution Form.
- Mail the completed form to: **Provider Dispute Resolution** Optum / Santa Barbara Select IPA 1901 N. Solar Dr. #200 Oxnard, CA 93036 **or** fill out this document electronically, save it, and then send it as an attachment via e-mail to: oi_pdr@optum.com

***Provider Name:**	***Provider Tax ID #:**
Provider Address:	

Provider Type:
☐ PCP ☐ HBP ☐ CAP Specialist (Specify Type)
☐ ASC ☐ PT/OT/ST ☐ FFS Specialist (Specify Type)
☐ DME ☐ Hospital - Outpt ☐ Other (Specify Type)

***Claim Information:** ☐ Single (complete information below) ☐ Multiple "Like" Claims (complete attached spreadsheet) # of Claims: _____

***Patient Name:**	**Date of Birth:**	**Patient Account #:**
***Health Plan ID #:**	***Health Plan Name:**	**Original Claim ID #:** (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
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution of a Billing Determination
☐ Contract Dispute
☐ Other: _____

***Description of Dispute:**
Expected Outcome:

Contact Name (please print)	**Title**	**Phone Number** ( )
Signature	**Date**	**Fax Number** ( )

☐ **Check here is additional information is attached.**

For IPA Use Only:
Incident #: _____ **Provider #:** _____

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(For use with multiple "LIKE" claims.)

Health Plan: _____ **Please print or type information.**

#	Patient Last Name*	Patient First Name*	Date of Birth	Health Plan ID #*	Service From / To Date*	Original SeaView Claim ID #	Original Claim Amt. Billed	Original Claim Amt. Paid	Description of Dispute	Incident # (IPA use Only)
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

For IPA Use Only:
Provider #: _____