

PROVIDER DISPUTE RESOLUTION REQUEST

SeaView 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** or fill out this document electronically, save it, and then send it as an attachment via e-mail to:
Optum / SeaView IPA
1901 N. Solar Dr. #215
Oxnard, CA 93036
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 if 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 #: _____