Provider Delegate Dispute Resolution Request

THIS FORM IS TO BE USED AFTER THE PROVIDER HAS EXHAUSTED ALL ATTEMPTS WITH THE DELEGATE

Instructions: Please complete the below form. *Fields with an asterisk (*) are required*. Be specific when completing the DESCRIPTION OF THE DISPUTE AND EXPECTED OUTCOME. ***Do not use this form if submitting corrections***. Provide additional information to support the description of the dispute. Delegate documentation should be included with submission including denial letters, remittance advice, authorizations.
A COPY OF THE CLAIM PREVIOUSLY PROCESSED IS REQUIRED.

How to Submit:

The preferred and most efficient method is **via FAX: 562-997-1835**
By mail, send to: SCAN Health Plan, Attn: DCR-Provider Disputes, PO BOX 21543 Eagan, MN, 55121

PROVIDER INFORMATION:

***Provider Name:**

Provider Address: Street Address | City | Zip

***Tax ID#:** ***NPI#:**

Check if Delegate: ☐ Contracted Provider ☐ Non Contracted Provider

CLAIM INFORMATION:

***Member Name:** Date of Birth (MM/DD/YYYY):

***Member ID#:** ***Member Acct#:**

Delegate Claim#: Scan Claim#:

***Service From Date (MM/DD/YYYY):** ***Service To Date (MM/DD/YYYY):**

***Original Claim Amount Billed:** Claim Amount Paid: Expected Additional Payment:

DISPUTE TYPE:

- ☐ CONTRACTED UNDERPAYMENT
- ☐ CONTRACTED RETRO AUTHORIZATION REQUEST
- ☐ CONTRACTED AUTHORIZATION DENIAL
- ☐ CONTRACTED RISK DISPUTE
  - ☐ OUT OF AREA ☐ HEALTH PLAN RISK
- ☐ NON CONTRACTED1st LEVEL PAYMENT DISPUTE
- ☐ NON CONTRACTED 2nd LEVEL PAYMENT DISPUTE
- ☐ NON CONTRACTED MEDICAL NECESSITY DENIAL
- ☐ NON CONTRACTED RISK DISPUTE
  - ☐ OUT OF AREA ☐ HEALTH PLAN RISK
- ☐ CAP DEDUCT REQUEST (SEE BELOW)

***DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

CAP DEDUCT REASON: INCLUDE ALL COMMUNICATIONS
☐ **IPA RISK** ☐ **HOSPITAL RISK WITH DELEGATE**

AMOUNT TO CAP:

***Contact Name** | **Title** | ***Phone (xxx) xxx-xxxx**

Email | ***Date MM/DD/YYYY** | ***Fax (xxx) xxx-xxxx**