Provider Dispute Resolution (PDR) Request

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.*** Do not include a copy of a claim that was previously processed. Provide additional information to support the description of the dispute.

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 Code

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

Check if ☐ Contracted Provider ☐ Non Contracted Provider **Provider**:

CLAIM INFORMATION:

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

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

Procedure Codes: 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 SEEKING RESOLUTION OF A BILLING DETERMINATION
- ☐ DISPUTING REQUEST FOR REIMBURSEMENT OF AN OVERPAYMENT
- ☐ NON CONTRACTED 1st LEVEL PAYMENT DISPUTE
- ☐ NON CONTRACTED 2nd LEVEL PAYMENT DISPUTE
- ☐ NON CONTRACTED MEDICAL NECESSITY DENIAL

***DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

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

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