Provider Dispute Resolution Request Form

Instructions:
Complete this form in full. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Provide supporting documentation for your appeal.

Mail the completed form to:
MediExcel Health Plan
Provider Dispute/Appeal
750 Medical Center Court, Suite 2
Chula Vista, CA 91911

Or fax the complete form to:
(978) 522-3777

Provider Name: _____ Provider Tax ID#: _____

Address: _____

Provider Type: ☐ MD ☐ Mental Hospital ☐ Hospital ☐ Ambulance ☐ Urgent Care

Other (please specify): _____

Claim Information (please indicate): ☐ Single ☐ Multiple "LIKE" Claims (please provide listing) # of claims _____

*Patient Name: _____ *Date of Birth: _____

*Health Plan ID: _____ Patient Account Number: _____

Original Claim ID # (if multiple cases, provide listing): _____

*Service Date (From/To): _____ / _____

Original Claim Amount Billed:_____ Original Claim Amount Paid:_____

Dispute Type:

☐ Claim seeking resolution for billing determination

☐ Appeal for medical necessity

☐ Other

***Description of Dispute:**

***Expected Outcome:**

***Contact Information:**

Name: _____ Title: _____

Telephone #: _____ E-mail: _____

☐ Check if additional information is attached (please include contact information on additional information sheets)