Provider Dispute Resolution

Definition of Provider Dispute: A Provider Dispute is a provider's written notice to Hill Physicians and/or the Enrollee's Health Plan challenging, appealing or requesting reconsideration of a claim for the following reasons:

- A claim has been denied
- A claim has been adjusted
- A claim has been adjudicated in a way that conflicts with the Hill Physicians Provider's contract, including reimbursement rates
- The provider has received a request for repayment of a claim that was overpaid

Required Information: All Provider Disputes must contain, at a minimum, the following information:

- provider's name
- provider's Tax ID number
- provider's contact information (address and phone number)

If the Provider Dispute concerns a claim or a request for reimbursement of an overpayment of a claim, provide in addition to the required information listed above**:**

- a clear identification of the disputed issue
- the applicable Date of Service
- a clear explanation of the basis for the Dispute, i.e., why the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect

If the Provider Dispute is not about a claim, provide in addition to the required information listed above:

- a clear explanation of the issue and the provider's position on the issue

If the Provider Dispute involves an Enrollee or group of Enrollees, provide in addition to the required information listed above:

- the name and identification number(s) of the Enrollee(s)
- a clear explanation of the disputed issue, including the Date of Service
- provider's position on the dispute
- Enrollee written authorization for provider to represent the Enrollee

How to Submit a Provider Dispute to Hill Physicians: Provider Disputes must be submitted in writing as follows. Forms are included at the end of this Claims section.

- Single Claim or Contractual Issue: Use the Provider Dispute Resolution Request Form.
- Several Claims With Same Dispute Basis: Use the Multiple "Like" Claims Log
- Claim Reports to Substantiate the Dispute: Use the Multiple "Like" Claims Batch Cover Sheet. Aging reports are not accepted.
- A written letter also may be submitted with applicable information as outlined in this section.

Submit Provider Disputes to Hill Physicians:

- By Mail: Hill Physicians
  Attention: Claims Research Resolution Unit
  P.O. Box 5080
  San Ramon, CA 94583-0980

- Physical Delivery: Hill Physicians
  Attention: Claims Research Resolution Unit
  2409 Camino Ramon
  San Ramon, CA 94583-0980

Time Period for Submission of Provider Disputes for Commercial and Medicare Benefit Plans:

- Provider Dispute must be received by Hill Physicians within 365 days from **the date of the Hill Physicians Explanation of Benefits (EOB)**.

- If Hill Physicians has not processed the claim, submit the Provider Dispute within 365 days of the Date of Service.

- Provider Disputes that do not include all required information, as set forth in this section, will be returned to the provider for completion. An amended Provider Dispute which includes the missing information must be submitted to Hill Physicians within thirty (30) working days of receipt of the Hill Physicians request for missing information.

Provider Dispute Inquiries: All inquiries regarding a Provider Dispute should be directed to Hill Physicians Customer Services Department at 800-445-5747.

Time Period for Resolution and Written Determination: Hill Physicians will issue a written determination within forty-five (45) working days of the date of receipt of the Provider Dispute or the amended Provider Dispute.

Past Due Payments: If the Provider Dispute or amended Provider Dispute involves a claim and is determined in whole or in part in favor of the provider, Hill Physicians will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of issuing the written determination.

PROVIDER DISPUTE RESOLUTION REQUEST

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 use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Hill Physicians Medical Group
  P.O. Box 5080
  San Ramon, CA 94583

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE
☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital
☐ ASC ☐ SNF ☐ Home Health ☐ DME ☐ Ambulance
☐ Rehab ☐ Other _____ (please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:___

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (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:

* DESCRIPTION OF DISPUTE:

DISPUTE TYPE
☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

EXPECTED OUTCOME:

( )

Contact Name (please print) | **Title** | **Phone Number**

Signature | **Date** | ( ) **Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

For Hill Physicians Use Only
TRACKING NUMBER _____ PROV ID#
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER MULTIPLE 'LIKE' CLAIMS BATCH SHEET

Provider Name:_____ Provider TIN: _____

Contact Person:_____ Phone Number: _____

Issue Type: (only one type per batch)

☐ Eligibility ☐ UPIN

☐ Authorization ☐ Timely Filing

☐ Edit Issues ☐ Benefits

☐ A report is attached ☐ Copies of claims are attached

Reports must include:

Patient's name (first and last) Date of birth Health Plan name
Claim number Date of Service Billed Amount
Amount Paid

Signature of Requester: _____ Date: _____

Hill Physicians Use ONLY

Batch Number: _____

Dispute Type:

☐ Claims ☐ Billing

☐ Contract ☐ Other

☐ Appeal of Medical Necessity _____

_____

PROVIDER DISPUTE RESOLUTION REQUEST LOG (For use with multiple "LIKE" claims)

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Provider Name: _____ Provider TIN: _____

Contact Person: _____ Phone Number: _____

Issue Type

☐ Eligibility ☐ UPIN ☐ Authorization ☐ Timely Filing ☐ Edit ☐ Benefits

Signature of Requester: _____ Date: _____

	Patient Name		Date of Birth	Health Plan ID Number	Claim Number	Date Of Service	Billed Amount	Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									

For Hill Physicians Use ONLY

Batch Number: _____

☐ Claims ☐ Billing ☐ Contract ☐ Appeal of Medical Necessity (UM)