Provider Dispute Form

Valley Health Plan

Claims, Medical, and Administrative Disputes
Phone: 1.408.885.7380 Option 4

Providers may complete this form to dispute a VHP claim denial. **Date:** _____

- Fields with an asterisk (*) are required for processing. Disputes with required fields missing may be returned.
- Provider should specify and attach any additional information or documentation to support the description of the dispute.
- For multiple "Like" disputes please complete and include the Multiple Like Dispute Form.
- This form can be mailed to:

  Valley Health Plan, Provider Dispute Resolution, P.O. Box 28387, San Jose, CA 95159
- If provider is appealing a denied authorization on behalf of the member, please contact Member Services Department at **1.888.421.8444**.
- For reconsiderations or retro-authorization requests, please contact Utilization Management Department at **1.408.885.4647**.
- If the claim is denied and VHP is requesting additional information, please submit a corrected claim with the additional information to the Claims Department.
- For routine claim follow-up status, instead of submitting a dispute, please call VHP at **1.408.885.4563**.

Provider Information:

*Provider NPI:	*Provider Tax ID:
*Provider Name:	
*Provider Address:	

Provider Type: ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF
☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other: _____

Dispute Type: ☐ Claim (Underpayment/Timely Filing/EOB, etc.) ☐ Contract
☐ Appeal of Medical Necessity / Utilization Management Decision (*Authorization # _____)
☐ Dispute of a Refund (request for reimbursement of overpayment)
☐ Other: _____

Claim Information: ☐ Single ☐ Multiple (*Fill out Multiple Like Dispute Form)

*Patient Name:	*Date of Birth:
*Member ID #:	Patient Account #:
*VHP Claim #:	*Date of Service:
*Original Claim Amount Billed:	Original Claim Amount Paid:

***Dispute Description** (Please refer to Page 2 if additional space is required)**:**

Attachments: ☐ Medical Records ☐ Authorization / Referral ☐ COB / EOB
☐ Proof of Timely Filing ☐ Proof of Eligibility ☐ AOR
☐ Invoice / Bill ☐ Other: _____

Expected Outcome (Please refer to Page 2 if additional space is required)**:**

Contact Information:

*Contact Name: _____ Title: _____ Phone Number: _____
*Signature: _____ Date: _____ *Fax Number: _____
*Mailing Address: _____
*Email: _____

Claim Information:

*Patient Name:	*Date of Birth:
*Member ID #:	Patient Account Number:
*VHP Claim #:	*Date of Service:
*Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Description (cont.):

Expected Outcome (cont.):

*Contact Name: _____ Title: _____ Phone Number: _____

*Signature: _____ Date: _____ *Fax Number: _____

*Mailing Address: _____

*Email: _____

Provider Dispute Form

For Use with Multiple "LIKE" Claims
Phone: 1.408.885.7380 Option 4

Date: _____

Multiple "LIKE" claims are for the same provider and dispute type but different members. Fields with an asterisk (*) are required. If filing multiple "LIKE" claims please complete all pages of the Provider Dispute Form and mail to: VHP, Provider Dispute Resolution, P.O. Box 28387, San Jose, CA 95159.

*Provider Name: _____ *NPI Number: _____

*Provider Address: _____

	*Patient Name		*Date of Birth	*Health Plan ID Number	*Original Claim Number	*Date of Service	*Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

*Contact Name: _____ Title: _____ Phone Number: _____

*Signature: _____ Date: _____ *Fax Number: _____

*Mailing Address: _____

*Email: _____