

# Provider Dispute Resolution Request

Sutter Health Plus

Please complete all sections of the form. Be specific when completing the description of dispute and expected outcome. You can provide additional information to support the dispute.

To inquire about the status of this dispute, contact Sutter Health Plus Member Services at 855-315-5800, 8 a.m. to 7 p.m., Monday through Friday.

## Mail your completed form to:



### MAIL

Sutter Health Plus  
P.O. Box 160366  
Sacramento, CA 95816

## Section A – Provider Information

\*Provider Name

\*Provider Tax ID

Medicare ID

Street Address (Please include suite number)

City

State

ZIP

Phone

### Provider Type:

MD

Hospital

DME

Home health

Mental health professional

ASC

Rehab

Ambulance

Mental health institutional

SNF

Other (Please specify type of "other")

## Section B – Patient Information

Member ID Number

Group Number

Last Name

First Name

MI

Date of Birth

Street Address (Please include apartment number)

City

State

ZIP

\* Required Fields

P-CC-24-002R

## Section C – Claims Information

**Number of Claims** .....

(If multiple claims, use attached spreadsheet)

**Claim ID Number**

**\*Service from/to Dates**

**Original Claim Amount Billed**

**Original Claim Amount Paid**

**Dispute Type:**

Claim

Contract dispute

Seeking resolution of a billing determination

Disputing request for reimbursement of overpayment

Appeal of medical necessity/utilization management decision

Other .....

**\*Description of Dispute and Provider's position:**

**Expected Outcome:**

**Contact Name and Title**

**Phone**

**Fax**

**Signature**

**Date**

# Multiple Claims Spreadsheet

No.	Patient Last Name	Patient First Name	Date of Birth	*Member ID Number	*Service from/to Date	ORIGINAL CLAIM			Expected Outcome
						Claim ID Number	Amount Billed	Amount Paid	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									