BROWN & TOLAND PHYSICIANS

BROWN & TOLAND PROVIDER DISPUTE RESOLUTION REQUEST FORM

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

INSTRUCTIONS

- Please complete the form below. 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 standard questions and claims adjustments, you may call Brown & Toland Customer Service at (415) 972-6002.***
- Mail the completed form to: Brown & Toland Customer Service Provider Dispute Unit
P. O. Box 70190
Oakland, CA 94612-0190

Fax the completed form to: (415) 972-6011

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

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF
☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance
☐ 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: (required for claims disputes)
* Service "From/To" Date:	Original Claim Amount Billed:	Original Amount Paid:

DISPUTE TYPE

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

*** DESCRIPTION OF DISPUTE** (Please attach additional information as needed)**:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature of Disputing Party	Date	( ) Fax Number