

Provider Dispute Resolution Request

Sutter Health Plan

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 Plan Customer Service at 855-315-5800, 8 a.m. to 7 p.m., Monday through Friday.

Mail your completed form to:



MAIL

Sutter Health Plan
P.O. Box 211624
Eagan, MN 55121

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-25-005R

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									