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 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-24-036R

Sutter Health Plan

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
- ☐ Seeking resolution of a billing determination
- ☐ Appeal of medical necessity/utilization management decision
- ☐ Contract dispute
- ☐ Disputing request for reimbursement of overpayment
- ☐ Other .....

***Description of Dispute and Povider'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									

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