SAN FRANCISCO HEALTH PLAN
Here for you

PROVIDER DISPUTE RESOLUTION (PDR) REQUEST FORM

- NOTE: If services have not been performed, and you are considering a Member Appeal, please follow this link to the Member Appeals & Grievances Process.
- Please complete the form below. All fields marked with an asterisk (*) are required.
- Be specific when filling out the DESCRIPTION OF DISPUTE/EXPLANATION & EXPECTED OUTCOME sections. Use additional pages if needed.
- Provide additional information to support your dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims refer to similar disputes from the same provider, but involve different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of this PDR Form.
- Mail this completed form to: **SAN FRANCISCO HEALTH PLAN**
  ATTENTION: CLAIMS
  PO BOX 194247
  SAN FRANCISCO, CA 94119

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:** **MEDICAL GROUP:**	
PROVIDER ADDRESS: (Indicate below where to mail PDR correspondence)	
TELEPHONE:	**FAX:**

PROVIDER TYPE: ☐ MD/PCP ☐ Specialist (Type: ______________) ☐ Mental Health Professional ☐ Mental Health Institution
☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other ________________________________
Please Specify

CLAIM INFORMATION: ☐ Single ☐ Multiple "LIKE" Claims *Number of claims:* _____

***PATIENT NAME:**		***DATE OF BIRTH:**
***SFHP ID:**	**PATIENT ACCOUNT NUMBER:**	**ORIGINAL CLAIM ID NUMBER:** (If multiple claims, use attached spreadsheet)
***SERVICE DATE(S):**	**ORIGINAL CLAIM AMOUNT BILLED:**	**ORIGINAL CLAIM AMOUNT PAID:**

***DISPUTE TYPE:**
☐ Claim ☐ Seeking Resolution of a Billing Determination ☐ Other: ____________________________
☐ Contract Dispute ☐ Disputing Request for Reimbursement of Overpayment *Please explain*
☐ PDR to appeal for Medical Necessity. Please check this box if you received a Notice of Action denial letter from our Utilization Management (UM) Department and you would like to appeal the denial for medical necessity. *Complete the next section.*

FILL OUT THIS SECTION TO REQUEST A PDR FOR MEDICAL NECESSITY REVIEW:
Please check one: ☐ Prior Authorization ☐ Concurrent Review Authorization reference number: ____________________________
Requested service: ____ Have these services been rendered? ☐ Yes ☐ No
Place of service:____ Date(s) of service: ______________________________________
Make sure to:

- Attach a copy of the NOA Denial Letter
- Attach any supporting clinical documentation; **NOTE: Please only send clinical records that are pertinent for the DOS you are contesting.**
- Provide a clear explanation as to why the denial decision should be overturned in the space provided below.

***DESCRIPTION OF DISPUTE/EXPLANATION:**

***EXPECTED OUTCOME:**

_______________________ _______________________ _______________________
Contact Name and Title (print) Signature/Date Phone#

For Health Plan/RBO Use Only
TRACKING # ____________________ PROV ID#____________________ CONT NON-CON MG/LOB REC'D DATE: