

PROVIDER APPEAL & DISPUTE REQUEST FORM

PLEASE READ BELOW BEFORE SUBMITTING THE FORM: *Fields with an asterisk (*) are required*

- If you are disputing claims payment regarding fee schedule, coding, and contract pricing, please contact our claims customer support department at [877-800-7423; Option 5] BEFORE submitting this form. **DO NOT CALL** for other reasons
- If you are appealing on behalf of a member for a service that has not been rendered, fax the pre-service appeal to (925) 313-6047. If member has Medi-Cal, be sure to include a completed [Member Consent Form](#) signed by the member
- Please provide supporting documents if needed. Sending unnecessary documents could delay the review process
- CCHP does NOT offer second level appeals. If you disagree with CCHP's decision, you may contact the Department of Managed Healthcare at <https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx> or by calling 1-877-525-1295
- Send the completed forms to:
 - Provider Appeals: Send via Encrypted email to Appeals@cchealth.org
 - Provider/Claim Disputes: Send via cLink Provider Portal or mail the forms to:

**Contra Costa Health Plan
ATTENTION: AGD Department
595 Center Avenue, Suite #100
Martinez, CA 94553**

PROVIDER INFORMATION

*PROVIDER NAME:	*PROVIDER NPI:
MEDICAL GROUP:	*PROVIDER TAX ID:
PROVIDER ADDRESS:	
PROVIDER PHONE NUMBER:	PROVIDER FAX NUMBER:
CONTRACTED WITH CCHP: <input type="checkbox"/> Yes <input type="checkbox"/> No	EMAIL ADDRESS:
PROVIDER TYPE: <input type="checkbox"/> Physician <input type="checkbox"/> Mental Health <input type="checkbox"/> Hospital <input type="checkbox"/> ASC/Outpatient <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other:	

CLAIM INFORMATION

CLAIM TYPE: <input type="checkbox"/> UB04 <input type="checkbox"/> CMS1500	CLAIM COUNT: <input type="checkbox"/> Single <input type="checkbox"/> Multiple: No. of Claims

PATIENT INFORMATION

*PATIENT NAME:	*DATE OF BIRTH:
*SUBSCRIBER NUMBER:	*ORIGINAL CLAIM NUMBER:
*DATE OF SERVICE(S):	*ORIGINAL BILLED AMOUNT:
*ORIGINAL PAID AMOUNT:	DENIAL CODE(S):

TYPE OF DISPUTE/APPEAL:

Pricing Dispute: <input type="checkbox"/> Contract <input type="checkbox"/> Coding/Modifier <input type="checkbox"/> Fee Schedule <input type="checkbox"/> Recoupment <input type="checkbox"/> COB/Third Party Liability Authorization Appeal: <input type="checkbox"/> Auth not required <input type="checkbox"/> Appeal for medical necessity <i>(Please complete the next section)</i>
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APPEAL FOR MEDICAL NECESSITY:

Appeal Type: <input type="checkbox"/> Prior Authorization <input type="checkbox"/> Concurrent Review	Authorization Number:
Requested Service(s):	Service Rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service(s):	Place of Service:

Please include the Notice of Action (NOA) letter if received and only the medical records for the DOS the appeal is for

APPEAL DESCRIPTION:

EXPECTED OUTCOME:

Contact Name:

Signature:

Date:

Phone Number: