HealthPlan OF SAN MATEO

Provider Dispute Resolution Request

Supplemental Form for Use with Multiple "Like" Claims

By submitting this form, I agree not to bill the member(s) named on it.

Initial or check here and sign at bottom of form: _____ ☐

For CareAdvantage only, also see page 2 of form.

This form provides additional information for the following dispute resolution request:

Provider Name: | For document reference, please indicate the member's name from main form: | Date

1

Member Name (Last, First) | DOB | Health Plan ID # | Original Claim ID # | Service Dates From / To

Original Claim Amounts

Billed: Paid:

Expected Outcome

2

Member Name (Last, First) | DOB | Health Plan ID # | Original Claim ID # | Service Dates From / To

Original Claim Amounts

Billed: Paid:

Expected Outcome

3

Member Name (Last, First) | DOB | Health Plan ID # | Original Claim ID # | Service Dates From / To

Original Claim Amounts

Billed: Paid:

Expected Outcome

4

Member Name (Last, First) | DOB | Health Plan ID # | Original Claim ID # | Service Dates From / To

Original Claim Amounts

Billed: Paid:

Expected Outcome

☐ Check here if additional information is attached. (Please do not staple additional information.)

This is supplemental form # _____ of _____ for this request.

For Health Plan Use Only

Tracking #:

Health Plan of San Mateo
Provider Dispute Resolution Request
Supplemental Form (Side 2)

◯ I am NOT a CareAdvantage Contracted Provider *(Please complete and sign the waiver below.)*

◯ I am a Contracted Provider. (*Please disregard the waiver below.)*

Health Plan of San Mateo
Waiver of Liability Statement

Member Name #1 from reverse side

Member ID / Member HIC Number

Member Name #2 from reverse side

Member ID / Member HIC Number

Member Name #3 from reverse side

Member ID / Member HIC Number

Member Name #4 from reverse side

Member ID / Member HIC Number

Provider Name

Dates of Service

Health Plan of San Mateo

As a provider of the mentioned member(s), I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date

H5428_CA_3070_08 (approved 02/08/2008)

Please see the Provider Dispute Resolution Request Form for sending instructions.

For Health Plan Use Only - Tracking #:

Provider ID #:

Print Form