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 ccLink 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: ☐ Yes ☐ No	EMAIL ADDRESS:
PROVIDER TYPE: ☐ Physician ☐ Mental Health ☐ Hospital ☐ ASC/Outpatient ☐ SNF ☐ DME ☐ Home Health ☐ Ambulance ☐ Other:	

CLAIM INFORMATION

CLAIM TYPE: ☐ UB04 ☐ CMS1500	CLAIM COUNT: ☐ Single ☐ 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: ☐ Contract ☐ Coding/Modifier ☐ Fee Schedule ☐ Recoupment ☐ COB/Third Party Liability

Authorization Appeal: ☐ Auth not required ☐ Appeal for medical necessity *(Please complete the next section)*

APPEAL FOR MEDICAL NECESSITY:

Appeal Type: ☐ Prior Authorization ☐ Concurrent Review	Authorization Number:
Requested Service(s):	Service Rendered? ☐ Yes ☐ 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: