KAISER PERMANENTE®

TRACKING NUMBER

PROVIDER DISPUTE SINGLE CLAIM RESOLUTION REQUEST

NOTE: WE STRONGLY URGE NON-CONTRACTED PROVIDERS NOT TO BILL HEALTH PLAN MEMBERS DURING THE DISPUTE RESOLUTION PROCESS.

PROVIDER NAME _____

PROVIDER TAX ID _____

PROVIDER TYPE
(CHECK ALL THAT APPLY)

- ☐ Contracted
- ☐ Non-Contracted
- ☐ Professional Provider
- ☐ Institutional Provider
- ☐ Other Provider: (please specify)

CLAIM INFORMATION

Required attachments: Copy of Original Claim and Remittance notification showing the denial

Patient Name:		
Kaiser Permanente Medical Record Number:	Kaiser Permanente Claim ID Number:	Patient Date of Birth:
Service "From" Date:	Original Claim Amount Billed:	Original Claim Amount Paid:

SUMMARY OF SERVICES PROVIDED

DETAILED DESCRIPTION OF REASON FOR DISPUTE
NOTE: Please attach any support for your dispute, which may include additional supporting documentation, medical documentation (if appropriate), any related laws/regulations you believe are relevant, or any other information you believe would be helpful.

_____ _____

Contact Name (Please Print) Title

_____ _____ _____

Signature Phone Number Date

Please return form to: **KP HAWAII – PROVIDER APPEALS, CLAIMS ADMIN DEPT, PO BOX 378021, DENVER, CO 80237-9998**