NORTH EAST MEDICAL SERVICES - MSO
PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS	
1. Complete the below form. Fields with an asterisk (*) are required. 2. Mail the completed form and supporting documents to: **North East Medical Services** **Attn: MSO Provider Claims Dispute** **1710 Gilbreth Rd** **Burlingame, CA 94010**	NEMS MSO only accepts first-level provider disputes requests. Second-level disputes or appeals must be submitted to the health plan.

*Provider Name:	*Provider NPI:
*Provider Address:	*Provider Tax ID:

CLAIM INFORMATION	
*Original Claim Number:	Claim Type: ☐ Professional ☐ Facility/Institutional
Original Claim Amount Billed:	Original Claim Amount Paid:
* Service "To & From" Date(s):	
*Patient Name:	*Date of Birth:
*Member Health Plan ID #:	Member's Health Plan:

DISPUTE DETAILS

*** Reason for Dispute:**

☐ Claim Underpayment
☐ Claim Overpayment
☐ Authorization On File
☐ Non-Duplicate Claim
☐ Covered Services
☐ Retrospective Eligibility
☐ Contract Dispute
☐ Disputing Request for Reimbursement of Overpayment
☐ Other (please indicate): _____

* **Description of Reason for Dispute** (be specific and attach necessary additional information for review):

* **Expected Outcome:**

_____ **Contact Name (please print)**
_____ **Title**
_____ **Phone Number**

_____ **Signature**
_____ **Date**
_____ **Fax Number**

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

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