MARCH Vision Care

Provider Dispute Resolution Request Form

Instructions:

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: MARCH Vision Care, 6601 Center Drive West, Suite 200, Los Angeles, CA 90045
- This form does not apply to the State of New Jersey

Provider Name*:	**Provider Tax ID #/Medicare ID #*:**
Provider Address:	

Provider Type: ☐MD ☐Mental Health Professional ☐Mental Health Institutional ☐Hospital ☐ASC ☐SNF ☐DME ☐Rehab ☐Home Health ☐Ambulance ☐Other (please specify):

Claim Information ☐Single ☐Multiple "Like" Claims (Complete attached spreadsheet) **Number of claims:**

Patient Name*:	**Date of Birth:**	
Health Plan ID Number*:	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date*: (Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**
Dispute Type: ☐ Claim ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Disputing Request for Reimbursement of Overpayment	☐ Seeking Resolution of a Billing Determination ☐ Contract Dispute ☐ Other:	
Description of Dispute:		
Expected Outcome:		

Contact Name (Please Print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

[ ] Check here if additional information is attached. Please do not staple.

For MARCH use only.

Tracking Number: Provider ID:

Contracted: Non-Contracted:

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(For use with multiple "like" claims)

Number	Patient Name Last	First	Date of Birth	Health Plan ID Number	Original Claim ID Number	Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

[ ] Check here if additional information is attached. Please do not staple.