KAISER PERMANENTE®

PROVIDER- CARRIER DISPUTE/APPEAL FORM

Please complete the following information for ***each*** disputed claim

Date: ________________

Provider: ______________________________

Tax ID: _______________________________

Contact Name: _________________________

Member/Patient Name: __________________

Member ID Number:_____________________

Date of Service:_________________________

Claim #: _______________________________

Billed Amount: ________________

Please check the appropriate box for appeal / dispute below:

- ☐ No authorization on file
- ☐ Denied in Error
- ☐ Denied (included in global)
- ☐ Timely Filing
- ☐ Incorrect Payment
- ☐ Other

Please explain the nature of your appeal/dispute:

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Please attach:

- Copy of the original claim form (HCFA 1500 or UB04)
- Copy of Kaiser Permanente denial
- Other appropriate supporting documentation for denials (which may include timely filing, authorization, COB, etc.)

Authorized Signature: ___________________

Date: ________________