



Provider Inquiry Form



Date Filed: _____

This form is used to address the following three provider inquiry types.

Please only select **one** inquiry type according to the options below:

- ☐ **Claim Inquiry:** Your claim finalized in the Alliance system, but you do not agree with the denial code or reimbursement rate. You request the Alliance review adjudication of the claim.
- ☐ **Provider Dispute:** Your claim finalized in the Alliance system and you have received a determination from the Claim Inquiry process. You request the Alliance review the Claim Inquiry Determination.
- ☐ **Corrected Claim:** You have changed information or included new documentation to a previously paid claim and request that the Alliance readjudicate the claim based on new information. You may check this box or complete the Corrected Claim Form referenced in policy 600-1009.
 - Note that for previously denied claims, you may make changes and resubmit directly to the Claims Department for review. No PIF form is required for resubmissions.

Step 1: Fill out provider and patient information, as well as billing information.

Provider and Patient Information:

Provider Group Name: _____
Rendering Physician _____
Provider Billing NPI _____
Provider Patient _____
Account #: _____
Patient Name _____
Date of Birth: _____
Alliance Member ID # _____

Provider Billing Information:

Contact Name _____
Contact Telephone Number _____
Contact Fax Number _____
Mailing Address for PIF/Dispute Resolution Letters:
Address _____
City/State/Zip _____

Step 2: Complete the grid below for each claim or authorization to be disputed.

Alliance Claims Control Number (CCN), or Authorization Number	Date of Service	Denied Procedure, CPT, or Revenue Code	Reason for dispute: Claim denial/ Reimbursement/ Denied Authorization *(only if services have been rendered)

Additional Information: _____

For more information regarding disputes, please review Section 17 of the Alliance Provider Manual or contact a Dispute Coordinator at 831-430-4105.

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www.thealliance.health



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Step 3: Return this form via email, fax or regular mail.

Email: CQID@thealliance.health

Fax: 831-430-5569

Regular mail:

Central California Alliance for Health
ATTN: Provider Inquiries and Disputes
1600 Green Hills Rd., Ste. 101
Scotts Valley, CA 95066

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