vision care MASTER COPY

Provider Dispute Resolution Request

INTERNAL USE ONLY

Submitting this form constitutes an agreement not to bill the patient during the claim appeal resolution process.

Please Print

Doctor name ______________________ Date ______________________

Doctor ID ______________________ Tax ID ______________________

Address ______________________ Phone ______________________

City, state, zip ______________________

Claim information

Number of claims appeals ☐ Single ☐ Multiple (indicate number of claims) ___

Patient name ______________________ Date of birth ______________________

Member ID or last four digits of SSN ______________________

Claim number ______________________ Date of service ______________________

Original claim amount billed $"________________ Original claim amount paid $______________

Summary of services provided ______________________

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Indicate reason for appeal and a detailed description of circumstances. Please attach any supporting documentation.

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Contact name ______________________ Title ______________________

Signature ______________________________ Date ______________________________

Phone ______________________________

Mail to: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350