KAISER PERMANENTE®
Network Service Administration

Provider Payment Dispute Resolution Submission Form

Provider Tax Identification Number:
_____
Provider Group Name & Address:
_____
Provider Contact Name & Phone Number:
_____
Provider E-mail Address:
_____
Date:
_____

PLEASE CHECK APPLICABLE BOX LISTED BELOW

ADMINISTRATIVE DENIALS	REIMBURSEMENT DENIALS
O **AUD02-** DENY, NOT AUTHORIZED, PROVIDER LIABILITY O **AUD04 –** DENY, AUTHORIZATION EXCEEDED-PROVIDER RESP O **AUD05 –** DENY, AUTHORIZATION DENIED – PROVIDER LIABILITY	O **CED11 –** DENY, NOT SEPARATELY PAYABLE PER VENDOR CONTRACT
O **CLD01-** DENY TIMELY FILING	O **CED29 –** DENY, PROCEDURE IDENTIFIED AS UNBUNDLED
O **CLD68-** DENY, RETROACTIVE COVERAGE TERMINATION	O **CLD10 –** DENY, MISSING/INVALID HCPCS O **CLD11-** DENY, MISSING/INVALID REVENUE CODE
O **BED03 –** DENY, VISIT LIMIT EXCEEDED O **BED04 –** DENY, BENEFIT DAYS LIMIT EXCEEDED	O **PRD03 –** DENY, INCLUDED IN CASE RATE O **PRD04-** DENY, INCLUDED IN GLOBAL CASE RATE
O **BED08-** DENY, PROCEDURE NOT COVERED	O **OTHER-** REIMBURSEMENT DENIALS
O **CLD24 –** DENY, PLACE OF SERVICE NOT CONSISTENT WITH PROCEDURE	
O **OTHER-** ADMINISTRATIVE DENIALS	

Please Provide Information Listed Below

Member Name:
_____
Member Medical Record Number (MRN):
_____
Total Billed Amount in Question:
_____
Claim Number(s):
_____

KAISER PERMANENTE®
Network Service Administration

Please Submit Appeal To:
Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998
Phone Number: 1 (877) 806-7470

CHECK LIST
(Please submit Appeal with Documents listed below)

FACILITY	PROFESSIONAL
O Detailed Appeal Letter or Appeal Filing Form. (If Appeal is submitted without Appeal Filing Form, the information listed below must be present: Reason for denial, member name & date of birth, medical record number, service dates and claim number(s)).	O Detailed Appeal Letter or Appeal Filing Form. (If Appeal is submitted without Appeal Filing Form, the information listed below must be present: Reason for denial, member name, medical record number, service dates and claim number(s)).
O Hospital Registration Sheet or Hospital Face Sheet	O Medical Records, Operative Procedure Reports, Radiology, Pathology Reports
O Complete Medical Records with Physician Orders O Copy of claim and Itemized Bill O If applicable: Medicare Summary Notice (MSN) O If applicable: Account Ledger and/or Screen Print-Out. (Timely Filing Denials)	O Copy of Claim O If applicable: Account Ledger and/or Screen Print-Out. (Timely Filing Denials) O If applicable: Medicare Summary Notice (MSN) O Other

Appropriate Appeal Submission Addresses:

Appeal Submission Address for Coverage Plans Listed Below:		
Signature, Select, Added-Choice Flexible Choice Option 1, Medicare Advantage and Medicare Plus: Mid-Atlantic Claims Administration Kaiser Permanente P.O. Box 371860 Denver, CO 80237-9998 Phone Number: 1-877-806-7470	**Flexible Choice Options 2 and 3:** P.O. Box 261130 Plano, TX 75026 **ATTN: Appeals** Phone Number: 1-800-392-8649	**Self-Funded:** P.O. Box 30547 Salt Lake City, UT 84130-0547 **ATTN: Appeals** Phone Number: 1-877-740-4117