Provider Dispute Resolution – Commercial Members
Frequently Asked Questions

1. Do I have to do a written dispute any time I have a claim issue?

No. You may continue to call DHMN-V at 805-604-3308, or the health plan with concerns or questions regarding a claim, utilization or contract issues, and we will continue to try to resolve these promptly and informally. This formal dispute process allows the provider to submit a formal written dispute and to be guaranteed a written resolution from DHMN-V within 45 business days.

2. Is there a specific form that I should use?

Yes. The forms are posted on our web site (www.dignityhealth.org/ventura) as Provider Dispute Resolution Request Form. Or we can fax or email this to your office. The form is not mandatory, but you must put the required information in writing. Use of the form will help expedite our resolution process.

3. What if I have claims that are being denied by the health plan as DHMN-V responsibility and DHMN-V is denying them as plan responsibility. Can I send these in as a formal dispute?

Yes, but you must submit it in writing, according to the guidelines established for the Provider Dispute Resolution Process. You may send the dispute to either DHMN-V or the plan.

4. What other types of issues can I submit through this process?

You can submit disputes when you would like reconsideration of a claim(s) that has been denied, adjusted or contested, resolution of billing determination, (such as whose financial risk it is) or other contract disputes, or a denial of utilization decision.

5. Can I use the provider dispute process to appeal a claim or UM decision on behalf of a member?

No. Member appeals MUST be submitted to the member's health plan and a member may ask you to assist or represent him or her in that appeal process. DHMN-V is not delegated by health plans to handle member appeals or grievances.

6. Do other medical groups / IPAs have the same process for sending in provider disputes?

Yes. Other groups as well as the health plans have a similar process for sending in provider disputes. You will have to get that process from the specific group or plan.

7. Can I submit a provider dispute in for a claim that is a year or more old?

Yes, as long as the payment or last action is less than 365 days old.

8. Does the provider dispute process apply to my Medicare HMO members?

No. The provider dispute resolution process only applies to the Commercial HMO and POS members. See your remittance advice or our website for the provider dispute resolution process as it pertains to Medicare HMO members.

9. Does this process apply to non-contracted providers?

Yes. For Commercial claims, they would follow the same procedures as a contracted provider. Non-contracted providers can only submit formal disputes for matters concerning claims, billing or payment. For Medicare Advantage members, see FAQ #8 above.