



PROVIDER DISPUTE RESOLUTION REQUEST (PDR)
Note: submission of this form constitutes agreement not to bill the patient
Non- Contracted Providers ONLY

Attn: Claims Department Health Plan of San Joaquin P.O. Box 30490, Stockton, CA 95213-30490

❖ **Note: Contracted Providers** must submit a provider dispute online through the Provider Portal/ Doctors Referral Express (DRE) <https://provider.hpsj.com/dre/default.aspx>

DISPUTE TYPE: Recovery Request Dispute

- Description: A letter was received regarding an identified overpayment and you do not agree with the determination

PROVIDER INFORMATION

Rendering Provider/Facility Name:	NPI #:
Pay to Affiliate Name:	Contact Name:
Provider Billing Address:	Phone #:
City/State:	Zip Code:

RECOVERY REQUEST INFORMATION

RU# _____ # of Claims _____

DISPUTE REASON:

- Check/Recoupment Already Applied
- CCS Denied
- Coordination of Benefits
- Disagree with findings: Coding/Rates/Other

- *Note: Copy of Recovery Request Letter and supporting documentation must be attached*

ADDITIONAL INFORMATION

Signature _____

Date _____