Health Plan of San Joaquin

CORRESPONDENCE COVER PAGE

Note: submission *of this form constitutes agreement not to bill the patient*

- If you are trying to submit corrections on a claim, please follow the **Corrected Claim** submission guidelines.

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 CORRESPONDENCE online through the Provider Portal/ Doctors Referral Express (DRE)* https://provider.hpsj.com/dre/default.aspx

CORRESPONDENCE TYPE: Additional Documentation Requested

- Description: *A claim/claim line or PDR denied for additional documentation*

PROVIDER INFORMATION

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

MEMBER INFORMATION

Patient Name:	HPSJ ID#	☐ Primary ☐ Secondary
Patient Date of Birth (DOB):	Patient Acct. #	

CLAIM INFORMATION (*Send only one Cover Page per claim)*

Claim #:	Service Date (s):	☐ IP ☐ OP ☐ PRO
PDR #	Authorization #	

Reason for documentation submission:

- ☐ Claim/Claim line denial
- ☐ PDR Determination Letter
- ☐ Authorization/MND Denial

Documentation Requested/Attached:

- ☐ Check/Claim RA
- ☐ Consent Form
- ☐ ER/Trauma Report
- ☐ Invoice/MSRP
- ☐ Itemized Statement
- ☐ Medical Records
- ☐ Other Supporting Documents
- ☐ Physicians Referral
- ☐ Transportation Report

ADDITIONAL INFORMATION