DESIGNATED PUBLIC HOSPITAL PROJECT
DISPUTE RESOLUTION FORM

Please complete this form for each admission's reason code finding in which you dispute the Department of Health Care Services decision transmitted in the "Onsite Review Summary Detail". Please be sure to submit this form along with all relevant documentation to support your conclusion via the dispute resolution secure website at https://eft.dhcs.ca.gov. If you do not have access to the website, please send an email to phpdispute@dhcs.ca.gov. Please submit all disputes for a given month's "Onsite Review Summary Detail" together.

Provider Name	Provider NPI Number	( ) Provider Phone Number
Address	City / State	Zip Code

Beneficiary Name

CIN Number

Medical Record Number

Admit Date:	
Discharge Date:	
# of Days in Dispute:	
Specific Dates in Dispute:	

Finding in Dispute: _____

Please provide detailed information regarding why you disagree with DHCS' decision. Attach all relevant additional documentation that supports the basis for your conclusion.

CONTACTS

DPHP Physician Name: _____ Phone Number: ( )

UR / Case Management Name: _____ Phone Number: ( )

Internal Use Only		
Dispute decision and justification:		
DPHP Physician Consulted?	Yes ☐	No ☐
Entered into Database?	Yes ☐	No ☐