Department of Health Care Services
Designated Public Hospital Project – Dispute Resolution Form

Please complete this form for each reason code variance you want to dispute from the Department of Health Care Services "Statement of Findings" (SOF) report. Also, submit all supporting documentation from the medical record to support your conclusion. This form and all supporting documentation must be submitted via the Dispute Resolution Secure website at: https://etransfer.dhcs.ca.gov. If you do not have access to the website, send an email to phpdispute@dhcs.ca.gov. Disputes are due within 60 calendar days from the date of the SOF report. All disputes in the SOF, for the given paid claim month, must be submitted together. Note: Providers should only dispute variances in which a claim adjustment was required in the SOF report.

Section 1: Provider Information and Facility Contacts	
Provider Name:	
Provider NPI Number:	
Provider Phone Number:	
Provider Address:	
Facility Physician Name:	
Physician Phone Number:	
UR / Case Manager Name:	
Case Manager Phone Number:	

Section 2: Statement of Findings Report at Issue	
Paid Claim Month / Year: (from SOF)	
Medical Record Number: (from SOF)	
Medi-Cal CIN:	
Claim Control Number (CCN):	
Paid Date "From" and "To":	
Reason Code Disputed: (Alpha/Numeric)	
Specific Dates Disputed:	

Section 3: Beneficiary and Hospital Stay Information	
Beneficiary Name:	
Admit Date:	
Discharge Date:	

Section 4: Why do you Disagree with the Findings from the SOF Report?	
Explain why you disagree with DHCS' findings (attach additional sheets if necessary):	
Be sure to attach necessary and supporting documentation from the medical record to support your explanation. Disputes are reviewed by consultants who do not have access to the medical record used at the time of the field office review.	