LEVEL 2
PROVIDER COMPLAINT RESOLUTION REQUEST

Level 1 request must be processed before a Level 2 can be submitted
Attach a copy of Level 1 Response and Medical Records not previously submitted

INSTRUCTIONS FOR LEVEL 2 COMPLAINT PROCESS

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Include clean/corrected claim or authorization request, when applicable.
- Mail the completed form to: **CalOptima Health Grievance and Appeals Resolution Services 505 City Parkway West Orange, CA 92868**

PRODUCT TYPE: ☐ Medi-Cal ☐ Commercial/Healthy Families ☐ Medicare/OneCare		
***Provider Name/ID:**		**Contracted:** ☐ YES ☐ NO
***Provider Billing Address:**		
***Patient Name:**		***Date of Birth:**
***Patient CIN/ID #:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
***Date of Service (From/To):**	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**
*** DESCRIPTION OF DISPUTE:**		
EXPECTED OUTCOME:		

*		*
Contact Name (please print)	**Title**	**Phone Number**
Signature	**Date**	**Fax Number**

Updated 9/2012

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(For use with multiple "LIKE" claims)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									