New Jersey Department of Banking and Insurance

Health Care Provider Application to Appeal a Claims Determination

AmeriHealth NEW JERSEY	Submit to: AmeriHealth New Jersey Provider Claim Appeals Unit P.O. Box 7218 Philadelphia, PA 19101

You have the right to appeal Our[1] claims determination(s) on claims you submitted to Us. You also have the right to appeal an apparent lack of activity on a claim you submitted.

DO NOT submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- Our determination indicates that We concluded the health care services for which the claim was submitted were not medically necessary, were experimental or investigational, were cosmetic rather than medically necessary or dental rather than medical. INSTEAD, you may submit a request for a Stage 1 UM Appeal Review to appeal such determinations. For more information, contact: [insert contact information].
- Our determination indicates that We considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services are not covered under the terms of the relevant health benefits plan, or because the person is not Our member. INSTEAD, you may submit a complaint. For more information, contact: [insert contact information]
- We have provided you with notice that we are investigating this claim (and related ones, as appropriate) for possible fraud.

You MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF Our determination:

- Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate you did not expect based upon the contract between you and Us, if any, or the terms of the health benefit plan.
- Resulted in the claim being paid at a rate you did not expect because of differences in Our treatment of the codes in the claim from what you believe is appropriate
- Indicated that We require additional substantiating documentation to support the claim and you believe that the required information is inconsistent with Our stated claims handling policies and procedures, or is not relevant to the claim.

You also MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- You believe We have failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law, and the terms of the contract between you and Us, if any
- Our determination indicates We will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from Us or another carrier for the services
- You believe we have failed to appropriately pay interest on the claim
- You believe Our statement that We overpaid you on one or more claims is erroneous, or that the amount We have calculated as overpaid is erroneous
- You believe we have attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that We have under-priced the current claim)

[1] A carrier's contractors (organized delivery systems and other vendors) are subject to the same standards as the carrier when performing claim payment and claim processing functions (including overpayment requests)on behalf of the carrier. Use of the words We, Us or Our includes our relevant contractors.

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YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED
SIGNATURE MUST BE COMPLETE AND LEGIBLE. THIS FORM MUST BE DATED.

A. Provider Information

1. Provider Name:		**2. TIN/NPI:**
3. Provider Group (if applicable):		
4. Contact Name:		**5. Title:**
6. Contact Address:		
7. Phone:	**8. Fax:**	**9. Email:**

B. Patient Information

1. **Patient Name**:	2. **Ins. ID**:

3. **Did You Attach a copy of** (check the appropriate response):

a. The assignment of benefits? ☐ Yes ☐ No ☐ NA

b. The **Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims?** (Consent form is **required for review of medical records** if the matter goes to arbitration.) ☐ Yes ☐ No

C. Claim Information

1. **Claim Number** (if known):	2. **Date of Service**:
3. **Authorization Number**:	

4. **Claim filing method** (check only one):
a. ☐ electronic (**submit** a copy of the electronic acceptance report from Our clearinghouse or Us)
b. ☐ facsimile (**submit** a copy of the fax transmittal)
c. ☐ paper claim by mail or courier service (**submit** a copy of the delivery confirmation evidence)

5. **Check the reason(s) why you are filing this appeal** (**check all that apply and be specific about billing codes and reason for dispute**):
a. ☐ Action has not been taken on this claim
b. ☐ Dispute of a denied claim → provide **date of denial**: _____/_____/_____
c. ☐ Claim was paid but not in a timely manner (provide more information):
☐ Yes ☐ No Additional information was requested? If yes, date:_____/_____/_____
☐ Yes ☐ No Additional information provided? If yes, date: _____/_____/_____
☐ Yes ☐ No Prompt Payment Interest paid correctly?
d. ☐ Claim was paid, but the amount paid is in dispute
e. ☐ Codes in dispute _____/_____/_____/_____/_____/_____/_____/
f. ☐ Dispute of an overpayment or the amount of overpayment (Attach a copy of overpayment request)
g. ☐ Dispute of carrier's offset amount against this claim (Attach a copy of A/R)

D. Reason for Appeal (Required)

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Provider Name: _____ Contact Number:_____

Member Name :_____ DOS:_____

You may provide additional information in an attachment to explain why you are disputing Our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Copies of any overpayment requests or A/R notice
- Information We previously requested that you have not yet submitted, if available
- Itemization of the provider contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract
- Pertinent correspondence between you and Us on this matter
- A description of pertinent communications between you and Us on this matter that were not in writing
- Relevant sections of the National Correct Coding Initiative (NCCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- Other documents you may believe support your position in this dispute (this may include medical records)

Attachments: ☐ **Yes** ☐ **No**

Signature:_____Date: ____/____/____

Important to Note

In order to ensure your Internal Payment Appeal is eligible to meet processing requirements for the External Binding Arbitration Program

- **The Internal Appeal Form must be sent to the address posted on Our website;**
- **The Internal Appeal Form must have a complete signature (first and last name);**
- **The Internal Appeal Form Must be Dated;**
- **There is a signed and dated Consent to Representation in Appeals of UM Determinations and Authorization for release of Medical records in UM Appeals and Independent Arbitration of Claims Form**