New Jersey Department of Banking and Insurance
Health Care Provider Application to Appeal a Claims Determination

Submit to:	Ameritas Life Insurance Corp.
If by mail, at:	Attn: Quality Control Unit, P.O. Box 82657, Lincoln, NE 68501-2657
If by courier service, at:	475 Fallbrook Blvd., Lincoln, NE 68521
If electronically:	qualitycontrol@ameritas.com

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A Health Care Provider has the right to appeal a Carrier's claims determination(s).[1] A Health Care Provider also has the right to appeal an apparent lack of activity on a submitted claim.

Health Care Providers:

- Must submit your internal payment appeal to the Carrier. **DO NOT** submit your internal payment to the New Jersey Department of Banking and Insurance.
- May use either this form, or the Carrier's branded *Health Care Provider Application to Appeal a Claims Determination* (which the Carrier may allow to be submitted online). The Carrier will accept either form.

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

- The Carrier's determination indicates that it considered the health care services for which the claim was submitted not medically necessary, experimental or investigational, cosmetic rather than medically necessary or dental rather than medical. INSTEAD, you may submit a request for a **Stage 1 UM Appeal Review**.[2]
- The Carrier's determination indicates that it considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services were not covered under the terms of the relevant health benefits plan, or because the person is not the Carrier's member. INSTEAD, you may submit a complaint. For more information, contact the Carrier's Provider Relations Department.
- The Carrier has provided you with notice that it is investigating the claim (and related ones, if any) for possible fraud.

You MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF the Carrier's 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 payment agreement between you and the Carrier
- Resulted in the claim being paid at a rate you did not expect because of differences in the Carrier's treatment of the codes in the claim from what you believe is appropriate
- Indicated the Carrier required additional substantiating documentation to support the claim and you believe that the required information is inconsistent with the Carrier's 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 the Carrier failed to adjudicate the claim, or an uncontested portion of the claim, in a timely manner consistent with law, and the terms of the contract between you and the Carrier, if any
- The Carrier's determination indicates it will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from another Carrier for the services
- You believe the Carrier failed to appropriately pay interest on the claim
- You believe the Carrier's statement that it overpaid you on one or more claims is erroneous, or that the amount it calculated as overpaid is erroneous
- You believe the Carrier has attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that the Carrier has under-priced the current claim)

If you do not know how to file a claims appeal with the Carrier, and you are a network provider, review your Provider Manual for instructions on how to file a Claims Appeal. If you are a not a network provider, you can find general contact information Licensed Insurance Carriers or Managed Care Entities on our website. Contact the Carrier for more specific instructions.

[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 processing functions (including overpayment requests) on behalf of the carrier. Use of the word Carrier includes the carrier and its relevant contractors.

[2]For more information: review your Provider Manual, or contact the Carrier's Utilization Management department or Provider Relations Department, or visit the New Jersey Department of Banking and Insurance's website at: How to File a Utilization Management Appeal

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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 the carrier's 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**