Section 10
Claim Payment and Provider Appeals

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Section 10

Practitioner/Provider Reimbursement

CDPHP follows a schedule on a weekly cycle for payment to practitioners/providers. If a practitioner is part of a group practice and shares a tax identification number with associates in the same practice, the group practice will receive a single check covering payment for all coverable services rendered to our members by practitioners in the group practice. An independent practitioner/provider will receive an individual check made payable to the practitioner/provider on a weekly basis.

Electronic Funds Transfer

- CDPHP offers Electronic Funds Transfer (EFT) of payments to our providers.
- You may select EFT payments regardless of whether your remittance type is 835 or paper.
- Please visit Zelis Healthcare at https://CDPHP.payeehub.org to obtain additional information and sign up for EFT services.

Any changes in the practitioner's/provider's status, address, tax identification number, medical group affiliations, cross coverage arrangements, etc., must be reported in writing to the attention of:

CDPHP Network Services
6 Wellness Way
Latham, NY 12110

If you do not currently receive an 835 electronic explanation of payments (EOP), a CDPHP payment voucher will accompany your reimbursement check for services provided. Either EOP will include the information needed to reconcile your check, including: group practice name, address, practitioner(s) name(s), CDPHP group practice and individual CDPHP practitioner identification numbers, date of issuance of voucher, tax identification number, check number, and amount of check.

A sample of the CDPHP payment voucher is included on the following pages for your review.

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC. (CDPHP)
6 Wellness Way
Latham, NY 12110

PAYMENT VOUCHER

CDPHP

(1) THE MEDICAL GROUP
(2) 123 SOUTH STREET
SUITE 100
ALBANY, NY 12203

(3) DATE: 2/14/08 (4) PAGE: 1
TIN#: (5) 345678910
(6) CHECK#: 0000621100 (7) G 1234
AMOUNT: (8) $ 95.22 SEQ#: 686

FOR TELEPHONE INQUIRIES CALL:
(518) 641-3500
1-800-926-7526

(9) Provider/NPI #: 12345678/1035277500 JONES (10)

(11) Claims Paid and Denied

(12) PATIENT NAME	(13) CLAIM #	(14) MEMBER #	(15) PT ACCT#	(16) DRG#	(17) DIAG#	(18) ADMIT	(19) DISCHAR	(20) LOS	(21) PLAN#
XXXXXXXXXX XXXXXX X	X000000000XX	000000000-00	13159		250.00	2/03/2008	2/03/2008	0	B3

(22) SERVICE #	(23) DATE	(24) PROC	(25) MOD	(26) BILLED	(27) DISALLOW	(28) DENY	(29) EX CODE	(30) DED/COPAY	(31) COINS	(32) RISK	(33) COB	(34) PAID	LOC
0100	2/03/2008	99213		55.00	11.28	0.00		8.00	0.00	5.68	0.00	30.04	11
0200	2/03/2008	36415		0.00	0.00	0.00	Z4	0.00	0.00	0.00	0.00	0.00	11
0300	2/03/2008	82150		35.00	22.92	0.00		0.00	0.00	1.57	0.00	10.51	11
0400	2/03/2008	82239		28.00	18.40	0.00		0.00	0.00	1.25	0.00	8.35	11
0500	2/03/2008	83665		45.00	28.34	0.00		0.00	0.00	2.17	0.00	14.49	11
0600	2/03/2008	85025		30.00	0.00	0.00		0.00	0.00	3.90	0.00	26.10	11
				193.00	80.94	0.00		8.00	0.00	14.57	0.00	89.49	

PATIENT NAME	CLAIM #	MEMBER #	PT ACCT#	DRG#	DIAG#	ADMIT	DISCHAR	LOS	PLAN#
XXXXXXXXXX XXXXXX X	X000000000XX	000000000-00	13159		272.0	2/03/2008	2/03/2008	0	B3

SERVICE #	DATE	PROC	MOD	BILLED	DISALLOW	DENY	EX CODE	DED/COPAY	COINS	RISK	COB	PAID	LOC
0100	2/03/2008	84460		13.00	6.41	0.00		0.00	0.00	0.86	0.00	5.73	11
				13.00	6.41	0.00		0.00	0.00	0.86	0.00	5.73	

PATIENT NAME	CLAIM #	MEMBER #	PT ACCT#	DRG#	DIAG#	ADMIT	DISCHAR	LOS	PLAN#
XXXXXXXXXX XXXXXX X	X000000000XX	000000000-00	10043		244.9	1/13/2008	1/13/2008	0	XH

SERVICE #	DATE	PROC	MOD	BILLED	DISALLOW	DENY	EX CODE	DED/COPAY	COINS	RISK	COB	PAID	LOC
0100	1/13/2008	99213		55.00	16.47	0.00		6.71	0.00	1.00	30.82	0.00	11
0200	1/13/2008	36415		8.00	5.00	0.00		0.00	0.00	0.00	3.00	0.00	11
0300	1/13/2008	87880		25.00	16.45	0.00		0.00	0.00	0.00	8.55	0.00	11
0400	1/13/2008	86580		50.00	38.79	0.00		0.00	0.00	0.00	11.21	0.00	11
0500	1/13/2008	83665		45.00	0.00	45.00	SJ	0.00	0.00	0.00	0.00	0.00	11
0600	1/13/2008	84432		60.00	39.11	0.00		0.00	0.00	0.00	20.89	0.00	11
				243.00	115.82	45.00		6.71	0.00	1.00	74.47	0.00	
		(35) TOTAL		449.00	203.17	45.00		14.71	0.00	16.43	74.47	95.20	

Summary Check Totals

PROVIDER		BILLED	DISALLOW	DENY	COPAY	RISK	COB	PAID
12345678	JONES	449.00	203.17	45.00	14.71	16.43	74.47	95.22
		449.00	203.17	45.00	14.71	16.43	74.47	95.22

Credits applied	0.00
Advances applied	0.00
Claims paid	95.22
Check amount	95.22

Explanation of Provider Payment Vouchers

Item #	Field	Explanation
1	Provider or Group	Name of Practice
2	Address	Payment address
3	Date	Date the payment voucher and check are issued
4	Page	Page number of the voucher
5	TIN #	Provider or group tax identification number
6	Check #	Check # issued
7	G or P	G=Pay to group with group number indicated P=Pay to provider
8	Amount	Reimbursement amount of check
9	Provider/NPI #	CDPHP provider identification number/NPI number
10	Name	Provider's last name
11	Claims Paid and Denied	These claims appear first on the voucher
12	Patient Name	Patient's full name will appear in alphabetical order
13	Claim Number	Assigned to the claim upon receipt by CDPHP
14	Member #	First nine characters identify the policy holder, and the last two digits identify the family members
15	PT ACCT #	Patient account number appears if included on the claim form
16	DRG #	Diagnosis related group appears if the hospital included on the UB04 claim form
17	DIAG #	Primary diagnosis code billed
18	Admit	First date of service billed
19	Discharge	Last date of service billed
20	LOS	Length of stay
21	PLAN #	Patient's benefit plan number as assigned by CDPHP
22	Service #	Line number assigned for services billed on the claim form
23	Date	Date of service
24	Proc	Procedure code
25	Mod	Procedure code modifier (See the following pages for modifier codes)
26	Billed	Amount billed to CDPHP for each procedure
27	Disallow	Amount that exceeds the current fee schedule. Cannot be billed to the patient.
28	Deny	Amount denied for service
29	Ex Code	Explanation code describes reasons to pay, pend or deny services. (The last page of the voucher will contain the applicable EX denial code definitions.)
30	Ded/Coins	Deductible or coinsurance payable by the patient after receipt of the payment voucher
31	Copay	Copayment due by the patient at the time of service
32	Risk	Risk withhold is a fixed percentage of the approved amount for the procedure. It is held in a separate account. This amount cannot be billed to the patient.
33	COB	Coordination of benefits is involved
34	Paid	Amount paid to the provider for services rendered after all disallowances, deductibles, copayments, withhold and COB have been deducted
35	Total	Total of all columns for claims paid and denied

Electronic Review of Claims

You may check the status of your claims via CDPHP's secure online provider interface at www.cdphp.com.

The site provides prompt access to your claims, whether you file them electronically or via the mailing of paper claims. Other member information available online includes daily member eligibility, copayments, benefit descriptions, and prior authorization history.

Access to these services requires a signed confidentiality agreement for each approved user, a user ID, and password. To get information regarding the features and benefits of these tools, or to make arrangements for access, contact the provider services department at (518) 641-3500 or 1-800-926-7526. You can download and print security forms from www.cdphp.com.

Follow-up on Outstanding Accounts

CDPHP recommends that you review and compare your electronic or paper voucher against your reimbursement check within a two-week period. **Requests for adjustment or additional review of a processed claim must be received by CDPHP within six months of the claim adjudication date**. If your request is not received by CDPHP within this time frame, CDPHP is under no obligation to honor the request and the previous decision remains on record. As stated in your CDPHP participating provider agreement, the member will not be held responsible for the claims in question, unless they were not covered by the member's benefit package and the member was informed, agreed to pay for the services, and has signed a specific waiver advising them of their responsibility. CDPHP records all provider contacts, via telephone and correspondence, in our electronic documentation system to ensure proper tracking of your requests.

A telephone call to the provider services department to obtain claim status that has already been provided on a previous voucher is not considered sufficient follow-up, nor is resubmission of a duplicate claim. A request for review of a previously processed claim must be received either by telephone or correspondence with either additional information provided verbally or supporting documentation submitted in writing.

In order to assist you with your account reconciliation and follow-up procedures, we suggest that the following steps may be helpful:

1) We strongly encourage all providers to reconcile their weekly reimbursement vouchers prior to contacting the provider services department. If you have any questions, contact the CDPHP provider services department at (518) 641-3500. We will need your NPI number to locate your claim history to help you reconcile your issues.
2) When contacting CDPHP by telephone, you will be asked for both your NPI number and individual tax ID number. Please have the voucher detail and any other information that may facilitate the discussion and the resolution. Important information includes member ID number with suffix, claim number, and date of service.
3) For adjustments that require supporting documentation, please submit a ***Provider Review Form*** (form #2076-0801 available from CDPHP, at no cost to your office by calling (518) 641-3500) for each claim in question. A copy of this form is included at the end of this section.
4) **Do not** discard your payment vouchers. It may be necessary for you to refer back to the information contained in your vouchers, therefore, please maintain these important payment reports.
5) Submit claim appeals within six months of the adjudication date by contacting the provider services department by telephone or in writing, and provide additional supporting information and a completed Provider Review Form.
6) If CDPHP is notified or determines it is necessary to retroactively terminate an employer's and or member's eligibility; any claims previously processed on behalf of the employer/member will be rescinded on the provider's weekly EOP. For details on proper reconciliation of these transactions, refer to the Credit Balances description that follows.

Resource Coordination Incentives

CDPHP does not compensate medical directors or other individuals conducting utilization review for denials of coverage or service. UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Credit Balances

A credit balance on your payment voucher is an indication that CDPHP re-reviewed and reprocessed a claim that was previously paid. This represents an overpayment to you. Rather than expect repayment from you, we will deduct the amount you owe us from future claims submitted for payment, within the same plan. In other words, HMO credits will be deducted from HMO claims. A credit for a member in a self-insured group will only be deducted from a voucher for the same employer group.

It is a wise practice to study your weekly ***Payment Vouchers*** regularly and carefully. If you detect a negative balance on a claim, your total payment for that week will be reduced by that amount. Note the claim number, member information and EX Code. Also, if the claim was billed with your internal patient account number, that information will also appear on the payment voucher. Compare the same information against previous ***Payment Vouchers*** until you locate the original claim and payment. Adjust that particular member's account accordingly.

There may be occasions when the adjustment from the re-review is sizeable and CDPHP may need to recoup the dollars owed us over the course of several payment periods and ***Payment Vouchers***. While we're continuing to approve and process your claims for "payment," we are reducing your negative balance. At some point, the negative balance will have zeroed-out and you will begin to receive a check again. In summary, the net amount of your reimbursement includes current claims due and previous adjustments.

Claim adjustments are usually the result of changes in member eligibility, code changes, claims processing or provider submittal errors. It is our intent to handle these adjustments promptly and keep your account and our members' accounts current. If you need assistance in reconciling a Payment Voucher, please contact the provider services department at (518) 641-3500 or 1-800-926-7526.

Provider Overpayment – NYS OMIG Overpayment

If you identify an overpayment that CDPHP has paid to you for services to a Medicaid patient, the NYS Office of the Medicaid Inspector General (OMIG) requires you to report, return, and explain the overpayment to CDPHP within sixty (60) days of identification. CDPHP will then report the recovery to the OMIG and NYS Department of Health in accordance with the terms of our contract with the department.

To report an overpayment you must take the following steps:

- Notify CDPHP by completing the ***Provider Review Form*** or contact CDPHP Provider Services by calling (518) 641-3500 or 1-800-926-7526.
- When utilizing the ***Provider Review Form***:
    - Fill out all fields completely, including member name and ID number, claim number, date of service, provider first and last name, provider NPI number, provider address, and provider group name.
    - In Section 4 (Reason for this adjustment request) select OMIG Overpayment
    - In Section 6 (Further Explanation) provide specific details to explain what issues you feel require additional review and/or adjustment. If more space is required, please attach a separate page.
    - Attach any additional supporting documentation.
    - Mail the completed ***Provider Review Form*** to:
      Provider Services Department, CDPHP, 6 Wellness Way, Latham, NY 12110.
    - If you have questions regarding the ***Provider Review Form***, contact CDPHP Provider Services.

Claim Appeals

The ***Provider Review Form*** is a tool that allows you to request in writing a review of claims processed. By using the ***Provider Review Form***, CDPHP is able to enhance our turnaround times and expedite the responses back to you. All requests for adjustment or review must be received by CDPHP within 180 days of the adjudication date of the claim.

CDPHP requests that our participating providers submit all appeals concerning claim adjudication decisions with the ***Provider Review Form***. Please refer to the sample ***Provider Review Form*** at the end of this section and review these instructions:

1) Use one ***Provider Review Form*** per claim to be reviewed.
2) Fill out all fields completely, including: member name, member ID number, and suffix, DOS, practitioner first and last name, NPI number, claim number, practitioner/provider address, and group name.
3) Indicate the pre-determined request that applies by checking the appropriate box. If your issue is not identified in this area of the form, check the box marked "Other" and provide a full explanation in the space provided.
4) The person submitting the ***Provider Review Form*** should sign the form and include his/her telephone number and the date the form is being submitted to CDPHP. Appeals submitted by a third-party billing company should indicate the name and address of the business in the appropriate area of the provider review form. By doing so, this ensures all return correspondence is directed to the appropriate location. Written replies will be directed to this person's attention on behalf of the CDPHP provider.
5) We ask that all copies are legible since we process your information through a scanner. Please do not highlight any information on the form or the supporting documents.
6) Provide specific instructions to explain to us what issues you feel require additional review and/or adjustment. If more space is required, please attach a separate page.
7) Attach any additional supporting documentation (e.g., primary carrier explanation of benefits, medical records, etc.) that was not available when the initial claim/documentation was submitted.
8) Mail your completed ***Provider Review Forms*** to: Provider Services Department, CDPHP, 6 Wellness Way, Latham, NY 12110. If you have any questions concerning the ***Provider Review Form***, feel free to contact the provider services department.
9) A second level claim review may be requested if new/additional information is supplied.

If the original determination is upheld or additional information is needed, CDPHP will provide a written response to claim appeals to the attention of the individual who has submitted the appeal.

If a claim appeal results in a reversal of the denied claim, the adjustment will be reflected on the weekly explanation of payment (EOP). If the claim is re-denied for another reason, this information will be reflected on the EOP.

It may be necessary for CDPHP to return your written inquiries if a ***Provider Review Form*** is not submitted with your request for review and or possible adjustment, or if clear instructions are not included.

The form incorporates many of the CDPHP explanation codes (EX-codes) which appear on your weekly reimbursement vouchers, and includes a space to indicate group name (if applicable), which will assist CDPHP in tracking your correspondence.

Provider Review Forms can be ordered directly through the CDPHP provider distribution program, at no cost to your office by calling (518) 641-3500. (See Section 21 of this manual.)

In accordance with Insurance Law section 3224-a(a), CDPHP complies with prompt pay requirements when overturning an appeal of an initial adverse decision. This applies to all member appeals (whether from the member or a properly executed designee) and those for which the provider has the right to submit on their own behalf under the law.

Provider Appeal Process

CDPHP® has a process by which practitioners and providers may request a review of an adverse claim determination. The ***Provider Review Form (PRF)*** is the tool for registering your request for an appeal.

Appeals on Behalf of a Member

All Lines of Business except Medicare—If a provider is appealing a decision on behalf of a member, check the box “Provider on Behalf of Member Appeal” on the *Provider Review Form*. You must also complete the form *Physician/Provider Designation Form Appeals/Grievances/Complaints*. The form must be signed and dated by the member and provider after the claim has been processed and denied by CDPHP. By using this form, your request will no longer be considered a provider appeal but would follow the path of a member appeal utilizing/ exhausting the member appeal rights. Details on the member appeal process vary by product type and can be found in the Member Handbooks.

Medicare Lines of Business—Ordering providers, referring providers and primary care physicians responsible for overseeing the care of a member may submit a pre-service appeal on their member’s behalf without a Appointment of Representation signed by the member, however, a valid signed Appointment of Representation is required for post-service appeals.

Appeals of Claims Denied as Experimental, Investigational, or Not Medically Necessary

A provider may file an appeal in writing on their own behalf when a retrospective claim is denied as experimental, investigational, or not medically necessary. Such appeals must be submitted within 180 days from the date of notification of denial, utilizing the ***Provider Review Form***. Select the box indicating “Medical Necessity Denial.”

CDPHP will acknowledge the appeal and if additional information is needed from your office to complete the review, CDPHP will request that information within 15 days.

CDPHP will complete the review of the appeal within 30 days from receipt.

Medicare, Federal Employees Health Benefits Program (FEHBP), and self-insured groups—If CDPHP upholds the initial medical necessity, experimental, or investigational decision for a member of CDPHP Medicare Choices, the Federal Employees Health Benefits Program, or a CDPHN group, a determination letter will be issued. This letter represents the final level of appeal review with CDPHP.

Commercial group coverage and state-subsidized plans (including Individual plans and Large/Small Group plans)—If CDPHP upholds the initial medical necessity, experimental, or investigational decision for an HMO or CDPHP Universal Benefits, Inc. member, a final adverse determination (FAD) letter will be issued indicating external appeal rights. Select Plan and HARP members may also have Fair Hearing rights, which will be indicated in the FAD letter. Members have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If the member asks for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, the member may continue to get services until the Fair Hearing decision. However, if the Fair Hearing decision is upheld, the member may have to pay the cost for the services they received while waiting for the decision.

To request an external appeal, the application must be sent to the New York State Department of Financial Services at the address indicated below:

New York External Appeals
NYSDFS
99 Washington Avenue, Box 177
Albany, NY 12210

The external review agent must receive the application within sixty (60) days from your receipt of the FAD. CDPHP does not have the authority to extend the 60-day filing period.

CDPHP requires a fee of $50 from providers requesting an external appeal. You must enclose a check or money order payable to CDPHP as part of your application to the New York State Department of Financial Services. Your check or money order will be returned if the appeal is decided in your favor.

The external review agent will make a written decision within 30 days of his or her receipt of your appeal. If the agent requests additional information within that 30-day period, the agent has an additional five business days to make a decision. The external review agent will notify you of the decision within two business days of making its decision.

If a provider files an external appeal concerning a “concurrent” utilization determination and the CDPHP determination is wholly upheld, the provider bears the entire cost of the appeal. If the appeal decision is upheld in part, CDPHP and the provider split the cost of the appeal evenly.

If the external agent upholds a denial for concurrent services that was filed by a provider on behalf of the member, the provider is prohibited from seeking payment from the member other than the copayment, coinsurance, or deductible that would be applicable if the care had been approved.

Please be aware that once you have exercised your external appeal rights for a medical necessity, experimental or investigational denial, the appeal process is then exhausted.

6 Wellness Way • Latham, NY 12110
(518) 641-3500 or 1-800-926-7526

Provider Review Form

Please use a separate form for each claim adjustment request, and file within six months of the original adjudication. Further completion instructions are supplied on the back of the form.

Section 1: Please complete all applicable fields

Date ____________ CDPHP Member ID# ____________ Claim ID# ____________ Date of Service ____________

Provider ID# or NPI# ____________ Member Name ____________ Provider Internal Patient Acct # ____________

Provider Name (first and last) ____________ Name of Person Submitting Request ____________ Phone# of Person Submitting Request ____________

Provider Group Name ____________ Provider Street, City and Zip Code ____________

Existing CDPHP Reference # (if any) ____________

◯ Check here if correspondence regarding this request should be sent to a third party on behalf of the provider (indicate third party): ____________

Section 2: Complete if appealing a retrospective denial

◯ Medical necessity denial (e.g., cosmetic, level of care, experimental/investigational)
◯ Provider appealing on behalf of member (Attach a completed *Physician/Provider Designation Form*)

Section 3: Complete if requesting adjustment related to coordination of benefits

◯ CDPHP is primary. ◯ CDPHP is secondary.

Attach EOB, EOP, or other documentation from other health plan, no-fault insurance, or Workers' Compensation.

Section 4: Reason for this adjustment request (please check one)

◯ Added or deleted charge(s)
◯ Date of service correction
◯ Diagnosis correction
◯ CPT/modifier correction
◯ Place of service correction
◯ Timely filing issue
◯ Duplicate denial error
◯ Unlisted code (invoice attached)
◯ Provider information correction
◯ Prior auth/notification for services billed
◯ Medicare requires inpatient for service rendered
◯ Unit/quantity correction
◯ Late charges
◯ Fee review
◯ OMIG Overpayment
◯ Other (explain below)

For claim corrections please attach a UB-04 or CMS-1500 showing all charges for the date of service.

Section 5: Documentation Enclosed

◯ Surgical or procedure note
◯ Ambulance record
◯ Radiology findings
◯ Inpatient records
◯ ER records
◯ Pathology report
◯ Indications for non-notification
◯ Complete billing ledger (include timely filing)
◯ Office note
◯ Manufacturer's invoice
◯ Code review/supporting documentation
◯ NDC number

Section 6: Further Explanation if Necessary

____

____

____

Instructions for Completing the Provider Review Form

Section 1—Information

Please include the name and the phone number of the person completing the form. In addition, if there is already a CDPHP Customer Service Event (CSE) or reference number, please include this as well.

Section 2—Provider Appeal Request

Complete this section when retrospectively appealing a claim denial involving care that CDPHP deemed cosmetic, not medically necessary, experimental/investigational, or provided at inappropriate level of service.

If the provider is appealing on behalf of the member, a completed *Physician/Provider Designation Form* must be included. This form must be signed and dated by the member after the claim has been processed and denied by CDPHP. Filing this form will mean that the request will no longer be considered a provider appeal but would follow the path of a member appeal.

Section 3—Coordination of Benefits Information

Complete this section when providing information relating to another insurer, No-Fault or Worker's Compensation claim, or behavioral health covered by SSI.

Section 4—Reason for This Adjustment Request

Indicate which reason best describes the situation that requires CDPHP review.

Section 5—Documentation Enclosed

Complete this section when documentation is required to process the request. Please refer to the additional notes below.

- **Pathology Report:** Pathology reports should be attached when a specific CPT code is submitted that requires knowledge of diagnosis, weight, or size. Please refer to definition in CPT and submit pathology report with procedure or surgical report when indicated.
- **Non-Notification:** Please submit an appropriate reason that CDPHP was not informed of the member's admission. This should include submitting incorrect insurance submitted, denial from other provider billed, phone log or faxes that pertain to obtaining the correct insurance information.
- **Code Review/Supporting Documentation:** Please submit medical records that support your referral. If requesting a second review, the information submitted should be additional to the first submission.
- **Unlisted Code:** Please include the description of what the unlisted code is so that the correct payment can be applied though medical review. If the unlisted code is a supply or DME, a manufacturer's invoice should be attached. If the unlisted code is a J code, then an appropriate NDC number should be submitted along with the medication records to indicate the amount administered.
- **Radiology Findings:** If submitted based on duplicate service denial, please attach all reports for review, not just the denied service.

Section 6—Further Explanation If Necessary

Complete this section only if you need to supply additional information that cannot be entered elsewhere on the form.

Provider Designation Form
Appeals/Grievances/Complaints

I designate my provider, ____ ,

to act on my behalf regarding the following issue:

______________________________ ______________________________
Member Name (Print) | Member ID Number

______________________________ ______________________________
Member Name (Signature) | Date

____
Provider Name (Print)

______________________________ ______________________________
Provider Name (Signature) | Date

Please return completed form to:

CDPHP Appeals and Complaints Department
6 Wellness Way
Latham, NY 12110
Appeals fax #: (518) 641-3401

Complete this form only after services are denied. This is not valid for CDPHP Medicare members. CDPHP Medicare members must use the CMS 1696 Appointment of Representative form available on www.cdphp.com.

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