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.