Provider Dispute Resolution Request

New Jersey Department of Banking and Insurance

Health Care Provider Application to Appeal a Claims Determination

United Healthcare | MARCH Vision Care	Submit to: UnitedHealthcare® | March® Vision Care If by mail or courier service, at: Attn: Medicaid Vision Appeals, PO Box 30988, Salt Lake City, UT 84130

You have the right to appeal Our 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 considered the health care services for which the claim was submitted not to be medically necessary, to be experimental or investigational, to be cosmetic rather than medically necessary or dental rather than medical. INSTEAD, you may submit a request for a Stage 1 UM Appeal Review. For more information, contact:
- 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:
- 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 payment agreement between you and Us.
- 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 underpriced the current claim).

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

United Healthcare | MARCH Vision Care

Submit to: UnitedHealthcare® | March® Vision Care
If by mail or courier service, at: 6601 Center Drive West, Suite 200
Los Angeles, CA 90045, Attn: Claims Appeals

YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED

A. Provider Information

1. Provider Name:		2. TIN:
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. Have you attached a copy of (check the appropriate response):	
a. the assignment of benefits? ◯ Yes ◯ No ◯ N/A	
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? (Not required for this appeal, but **required if** the matter goes to arbitration.)* ◯ Yes ◯ No	

C. Claim Information

1. Claim # (if known):	2. Date of Service:
3. 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. ◉ mail or courier service (**submit** a copy of the delivery confirmation evidence)	
4. Read the following and check the condition(s) that describe this appeal: 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 Interest paid correctly? d. ☐ Claim was paid, but the amount is in dispute (not including interest) e. ☐ Dispute of carrier's allegations of overpayment or amount of overpayment f. ☐ Dispute of carrier's offset amount against this claim	

In an attachment, explain why you dispute handling of the claim. Be specific about billing codes. Also, submit (copies only):

- The relevant CMS 1500(s) or UB92(s)
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Information We previously requested that you have not yet submitted, if available
- Itemization of the contract provisions you believe We are not complying with, if any
- 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 (CCI) 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

Signature:_____ Date: _____