

SECTION J APPEALS

AAHP PROVIDER RECONSIDERATION/RE-DETERMINATIONS (Collectively “Appeals”)

CLAIMS CUSTOMER SERVICE:

- AAHP encourages providers to contact Claims Customer Service at 602-824-3900 or 1-888-864-1114 for assistance with questions or issues surrounding claim payment, partial payment, or non-payment. As a reminder, please submit all claims within 180 days for both contracted and non-contracted providers. A provider may dispute any claim payment, payment reduction or claim denial, by filing an appeal.

APPEALS:

- If you would like to file an appeal request, such as in response to a claim payment, payment reduction or claim denial by AAHP, please submit the request in writing within 60 days from the date of the remittance advice or notice of adverse action. Be sure to include a cover letter explaining the basis for the appeal along with any required documentation to support the request, such as medical records. Failure to timely request an appeal is deemed a waiver of all rights to review.
- Providers may submit appeal requests by mail to:

Abrazo Advantage Health Plan
Attn: Provider Appeals Unit
7878 North 16th Street, Suite 105
Phoenix, Arizona 85020

Fax requests to AAHP at: 602-674-6673 or 1-866-832-5469 if outside of Maricopa County

- AAHP acknowledges any appeal request received within five (5) business days of receipt. The appeal is reviewed and a decision rendered within 30 days of receipt. AAHP may request an extension of up to 14 days, if needed.
- If AAHP approves the reconsideration request, the provider receives a corrected payment and remittance advice. However, if AAHP upholds its original decision (e.g. denial) on any claim for medical services, it forwards the file automatically to the CMS designated Independent Review Entity (IRE) to review your case. The IRE is contracted with the federal government and is not part of AAHP. AAHP tells you in writing whenever your appeal is sent to the IRE for review.

PROVIDER APPEALING ON BEHALF OF A MEMBER:

- If AAHP denies services for a member in whole or part, a provider can file an appeal on behalf of a Member within 60 days of the original denial notice.
- A provider who elects to use this option needs to complete an *Appointment of Representative* form (AOR) as required by CMS.
- Please copy the AOR form (see the following pages) or visit the AAHP (www.abrazoadvantage.com) or CMS

SECTION J APPEALS

(<http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>) website to print and/or download this form.

- The AOR must be signed by both the provider and the Member and must accompany the appeal request.
- Send completed AOR forms to the above AAHP mailing address and/or fax number.
- Completion of an AOR allows the provider to act on the Member's behalf during the appeal process. The provider has all of the rights and responsibilities of an enrollee, or party, in obtaining an organization determination or in dealing with any of the levels of the appeal process.

APPOINTMENT OF REPRESENTATIVE

NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER
---------------	---

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
STREET ADDRESS		PHONE NUMBER <i>(with Area Code)</i>
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE		DATE
STREET ADDRESS		PHONE NUMBER <i>(with Area Code)</i>
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
-----------	------

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

SIGNATURE	DATE
-----------	------

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council (MAC) review, or a proceeding before an ALJ or the MAC as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for MAC review

Approval of a representative's fee is not required if (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

WHERE TO SEND THIS FORM

Send this form to the same location where you are sending (or have already sent) your appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



Abrazo Advantage Health Plan (HMO)

An Affiliate of Abrazo Health Care

PROVIDER RECONSIDERATION ("APPEAL") FORM

All standard provider reconsideration ("appeals") regarding claim payment, partial payment, or non-payment must be submitted within 60 calendar days from the date of the notice of documentation (i.e. remittance advice or notice of adverse action).

Requests for reconsideration should include:

1. A completed Provider Reconsideration Form OR a letter detailing the factual and legal basis for the dispute. **(Complete one form for each reconsideration).**
2. A copy of the original claim and remittance advice.
3. **NON-CONTRACTED** providers must submit a signed and dated Waiver of Liability Statement which states the provider will not bill the member regardless of the outcome of the reconsideration. AAHP is unable to accept the reconsideration until the waiver is received (see 42 CFR §422.600). If the waiver is not received at the conclusion of the reconsideration timeframe (60 days) the reconsideration case is forwarded to an Independent Review Entity (IRE) with a request for dismissal. The IRE is contracted with the Centers for Medicare & Medicaid and is not affiliated with AAHP.
4. Supporting documentation such as medical records, operative reports, etc. is required when the claim involves a clinical component (denied inpatient days, bundling issues, or services denied for lack of prior authorization).
5. Mail or fax the completed form(s) and documentation to:
Abrazo Advantage Health Plan Fax: 602-674-6673
Attn: Provider Appeals
7878 N. 16th St. #105
Phoenix, AZ 85020
6. Reconsiderations are acknowledged within five (5) business days. A written decision is mailed within sixty (60) calendar days from receipt of the reconsideration request. When AAHP upholds its original decision in full or in part, the case file is forwarded to the Independent Review Entity (IRE). The IRE reviews the case and makes a final determination on the reconsideration. In some cases, the provider may need to file an Independent Payment Dispute Resolution directly with the Payment Dispute Resolution Contractor. Please refer to the resolution letter upon receipt to determine which process is applicable.

Provider Information:

Date:	Provider / Group Requesting Review:		
Contact Name (First Name, Last Name):			Department:
Correspondence Address:			
Fax Number:		Phone Number:	

Member Information:

Member Name:	Date of Birth:	AAHP I.D.:
--------------	----------------	------------

Claim Information:

Claim / Form #:	Date of Service:				
Procedure Code(s) disputed:					

Reason/Supporting Information for Reconsideration

Clinical Documentation Attached Yes No

--