Abrazo Advantage Health Plan (HMO)

PROVIDER RECONSIDERATION ("APPEAL") FORM (Rev 1/2010)

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

Requests for appeal should include:

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

Date Submitted:	Contact Name:	
Contact Phone Number:	Contact Fax Number:	
Provider of Disputed Service:		Provider F#:
Member Name:	Member Date of Birth:	Member ID#:

CLAIM INFORMATION

Claim Number (s)	Date(s) of Service	CPT / HCPCS / Revenue Code	Modifier (if applicable)	Amount Billed	Amount Paid
				$	$
				$	$
				$	$
				$	$
				$	$

REASON FOR DISPUTE (check appropriate box)

☐	Claim Bundling	☐	Additional Bed Days
☐	Prior Authorization Issue	☐	Tier Level
☐	Timeliness of Claim	☐	Non-Covered Benefit
☐	Corrected Claim (re: ICD-9, CPT, HCPCS, Revenue Code, Modifier, Missing Documentation, etc)	☐	Medical Necessity
☐	Incorrect Reimbursement	☐	Ineligible Member
☐	Other Insurance / Missing EOB	☐	Provider Eligibility
☐	Other (specify):		

Reason/Supporting Information for Appeal:

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