



In accordance with the Health Claims Authorization, Processing and Payment Act (HCAPPA) enacted in January 2006, health care providers wishing to request an appeal related to claims arising from services rendered on or after July 11, 2006 should use the *Health Care Provider Application to Appeal a Claims Determination Form*. A copy of the required form and related instructions follow.

All elements in the form should be completed and submitted to the following address:

For claims submitted for services rendered to Aetna New Jersey members

CareCore National, LLC
PO Box 798
Lake Katrine, N.Y. 12449

For claims submitted for services rendered to HealthNet New Jersey members

CareCore National, LLC
PO Box 759
Lake Katrine, N.Y. 12449



New Jersey Department of Banking and Insurance

Health Care Provider Application to Appeal a Claims Determination

A Health Care Provider has the right to appeal a Carrier's claims determination(s).¹ A Health Care Provider also has the right to appeal an apparent lack of activity on a submitted claim.

If you are a Health Care Provider:

- You must submit your appeal to the Carrier. DO NOT submit it to the New Jersey Department of Banking and Insurance.
- You may use this form, or the Carrier's modified *Health Care Provider Application to Appeal a Claims Determination* (which the Carrier may allow to be submitted online). The Carrier will accept either form.

DO NOT submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- The Carrier's determination indicates that it 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: review your Provider Manual, or contact the Carrier's Utilization Management department or Provider Relations Department, or visit the New Jersey Department of Banking and Insurance's website at: [How to File a Utilization Management Appeal](#).
- The Carrier's determination indicates that it considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services were not covered under the terms of the relevant health benefits plan, or because the person is not the Carrier's member. INSTEAD, you may submit a complaint. For more information, contact the Carrier's Provider Relations Department.
- The Carrier has provided you with notice that it is investigating the claim (and related ones, if any) for possible fraud.

You MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF the Carrier's 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 the Carrier
- Resulted in the claim being paid at a rate you did not expect because of differences in the Carrier's treatment of the codes in the claim from what you believe is appropriate
- Indicated the Carrier required additional substantiating documentation to support the claim and you believe that the required information is inconsistent with the Carrier's 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 the Carrier failed to adjudicate the claim, or an uncontested portion of the claim, in a timely manner consistent with law, and the terms of the contract between you and the Carrier, if any
- The Carrier's determination indicates it will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from another Carrier for the services
- You believe the Carrier failed to appropriately pay interest on the claim
- You believe the Carrier's statement that it overpaid you on one or more claims is erroneous, or that the amount it calculated as overpaid is erroneous
- You believe the Carrier has attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that the Carrier has under-priced the current claim)

If you do not know how to file a claims appeal with the Carrier, and you are a network provider, review your Provider Manual for instructions on how to file a Claims Appeal. If you are not a network provider, you can find general contact information [Licensed Insurance Carriers](#) or [Managed Care Entities](#) on our website. Contact the Carrier for more specific instructions.

¹ 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 word Carrier includes the carrier and its relevant contractors.

Carrier Name:			
Carrier Address:			
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:
	Medical Record:		3. Have you attached a copy of (check the appropriate response):
	a. the assignment of benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		
	b. the <i>Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims?</i> (Not required for this appeal, but required if the matter goes to arbitration.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
C. Claim Information	1. Claim # (if known):		2. Date of Service:
	3. Claim filing method (check only one):		
	a. <input type="checkbox"/> electronic (submit a copy of the electronic acceptance report from Our clearinghouse or Us)		
	b. <input type="checkbox"/> facsimile (submit a copy of the fax transmittal)		
c. <input type="checkbox"/> 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. <input type="checkbox"/> Action has not been taken on this claim			
b. <input type="checkbox"/> Dispute of a denied claim → provide date of denial : ____ / ____ / ____			
c. <input type="checkbox"/> Claim was paid but not in a timely manner (provide more information):			
<input type="checkbox"/> Yes <input type="checkbox"/> No Additional information was requested? If yes, date: ____ / ____ / ____			
<input type="checkbox"/> Yes <input type="checkbox"/> No Additional information provided? If yes, date: ____ / ____ / ____			
<input type="checkbox"/> Yes <input type="checkbox"/> No Interest paid correctly?			
d. <input type="checkbox"/> Claim was paid, but the amount is in dispute (not including interest)			
e. <input type="checkbox"/> Dispute of carrier's allegations of overpayment or amount of overpayment			
f. <input type="checkbox"/> 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 HCFA 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: ____ / ____ / ____