Independent Review Request Form

Please complete this form and mail it back to us. You will be copied on our correspondence concerning this matter. Please provide documentation that supports your complaint.

Complainant Information

Provider Representative

First Name: Last Name:

Street Address:

City: State: Zip Code:

Phone Number: Daytime/Alternate:

Fax Number: Email Address:

Provider Name & NPI

Name: NPI #:

Rendering Provider: Billing Provider:

Street Address:

City: State: Zip Code:

Phone Number: Daytime/Alternate:

Fax Number: Email Address:

MCO Plan Information

My Complaint is against:

☐ ACLA ☐ Aetna ☐ Healthyblue ☐ LHCC ☐ UHC

Provider Type:

☐ Hospital ☐ FQHC ☐ RHC ☐ BH ☐ Physician ☐ Other

Date of Service(s):

Start Date: End Date:

Independent Review Request Form

Please give a written description of the problem: (Attach additional pages if needed)

- Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim. Include all pertinent information.
- Attach copies of pertinent documentation, including correspondence from the plan and remittance advices.

Do you request your claims to be aggregated?

- ☐ YES
- ☐ NO

Only claims involving a common question of fact or law may be aggregated. The fact that a claim is not paid does not create a common question of fact or law. If you wish to aggregate your claims, explain the common question of fact or law:

Independent Review Request Form

Initial Claim Submission to MCO Date:

(Attach a copy of the Provider Claim)

Initial MCO Claim Denial or Recoupment Date:

(Attach a copy of the MCO Denial or Recoupment Advice.)

Date Provider submitted written Reconsideration Request to MCO:

(Attach a copy of the Provider's Reconsideration Request.)

Date Provider received written Reconsideration Denial:

(Attach a copy of the Provider's Reconsideration Denial)

Are you an In-network provider with this MCO?

☐ Yes ☐ No

Explain if needed:

Reason(s) for Complaint

☐ Untimely Filing ☐ Claim Recoupment Error ☐ Claim Paid Incorrectly

☐ Medical Necessity ☐ Neither Paid nor Denied ☐ Lack of Authorization

☐ Other _____

Only claims which meet ALL requirements set forth in La-RS 46:460.81 are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a MCO member are not eligible.

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ACKNOWLEDGMENT OF FEE OBLIGATION

By my signature below, I hereby request Independent Review of the above claim, pursuant to La-RS 46:460.81. I also confirm that the above mentioned disputed claim will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer's fee. I also understand that there is a mandatory fee of $750.00 per claim and If I have a contract with the MCO, the MCO is initially responsible for paying the fee. I further understand that if the reviewer determines the MCO correctly denied payment of this disputed claim(s), then I must reimburse the MCO for the reviewer's fee as established by the Selection Panel for reviewers.

If you are not the aggrieved provider, what is your relationship to the provider?

I declare that the information I've furnished is true and accurate.

Signature:	**Date:**