amcno

THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

THIRD PARTY PAYOR REVIEW FORM

The Practice Management Department of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been in existence for more than 20 years. When AMCNO members or their office staff has specific practice management issues, questions or concerns with the numerous insurance carriers, the practice management department is always available to address or investigate these and other issues. This third party payor review form is a tool physician offices may utilize when specific issues/problems with an insurance carrier arise.

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Date Submitted: _____

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____

CPT code in question: _____ Expected amount of reimbursement: _____

Patient First Name Only: _____ ***Insurance ID#: _____
(**Please do not include the patient's last name**)

Date of Service_____

Issue or Concern: (mark all that apply)

Types of Denials
- Preauthorization
- Referral
- Claim

Payment Issues
- Delay in payment
- Late payment pattern
- Pre/Post payment review

Claim Patterns
- Down coding
- Recording of claims
- Lost claims
- Data entry errors by insurer
- Supporting documents missing
- Pertinent claim information missing

Documentation Requests
- Copy of medical record
- Operative report

Telephone Access
- Continuous busy signal
- Excessive hold time
- Numerous calls for a single claim
- Other (specify) _____

Attach a letter describing the problem and detailing the sequence of events between your office and the insurance company. Also please attach copies of pertinent documentation including the claim, explanation of benefits, and any correspondence.

IMPORTANT: Please do not send confidential patient information without the proper patient consent. **Remove all identifying information, such as patient's last name, from documentation prior to submitting to AMCNO**. ***All claims must have a numeric identifier as a form of identification. If the patient does not have an insurance identification number, use the primary policyholder's social security number or the patient's social security number.** Please be advised that the AMCNO may share this information with the insurance carrier, relevant state agencies, or other parties to expedite resolution of your problem. The submission of this form and any attached information is consent to release this form and information, as appropriate, by the AMCNO. Please mail or fax this completed form to the **AMCNO, Practice Management Department, 6100 Oak Tree Blvd., #440, Cleveland, Ohio 44131 or fax (216) 520-0999.** If you have any questions regarding this form and its use or additional issues or concerns, please contact the practice management department at (216) 520-1000 or e-mail concerns@amcnoma.org