

THIRD PARTY PAYOR REVIEW

The Practice Management Department of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) has been in existence for over 15 years. When AMC/NOMA members or their office staff have 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 useful tool for offices to utilize when they have a specific issue with an insurance carrier that requires immediate attention.

Physician's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Date Submitted: _____

Insurance carrier: (mark all that apply)

- | | | | |
|---------------------|----------------|-----------------------|----------------------|
| Nationwide Medicare | Medicaid | Workers' Compensation | Aetna/Prudential |
| Managed Care Plan | Medical Mutual | Anthem | Commercial Insurance |
| United Healthcare | Cigna | PPO | Other(s) |

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____

Amount in question: \$ _____

Issue or Concern: (mark all that apply)

- | | | | |
|--------------------------------|------------------------------|-------------------------------------|--------------------------------------|
| <u>Types of Denials</u> | <u>Payment Issues</u> | <u>Claim Patterns</u> | <u>Documentation Requests</u> |
| Preauthorization | Delay in payment | Down coding | Copy of medical record |
| Referral | Late payment pattern | Recording of claims | Operative report |
| Claim | Pre/Post payment review | Lost claims | |
| | | Data entry errors by insurer | |
| | | Supporting documents missing | |
| | | Pertinent claim information missing | |

- Telephone Access**
 Continuous busy signal
 Excessive hold time
 Numerous calls for a single claim

Other (specify) _____

Brief Description of the Problem:

IMPORTANT: Attach copies of pertinent documentation including the claim, explanation of benefits, and any correspondence. Please do not send confidential patient information without the proper patient consent. Please be advised that the AMC/NOMA 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 AMC/NOMA. Please mail or fax this completed form to the AMC/NOMA, Practice Management Department, 6000 Rockside Woods Blvd., #150, Cleveland, Ohio 44131-2352 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, ext. 320 or e-mail at concerns@en.com.