

Provider Payment Dispute Resolution Submission Form

Provider Tax Identification Number: _____ Provider Group Name & Address: _____ Provider Contact Name & Phone Number: _____ Provider E-mail Address: _____ Date: _____

PLEASE CHECK APPLICABLE BOX LISTED BELOW

ADMINISTRATIVE DENIALS	REIMBURSEMENT DENIALS
<input type="radio"/> BNA01 - NO AUTHORIZATION	<input type="radio"/> ALCNT - NOT REIMBURSABLE PER CONTRACT
<input type="radio"/> NOLD1 - UNTIMELY FILING	<input type="radio"/> X0009 - UNBUNDLED CHARGES
<input type="radio"/> NINEL - INELIGIBLE MEMBER	<input type="radio"/> NPRV2 - NO PROVIDER CONTRACT ON FILE FOR DATE/TYPE OF SERVICE
<input type="radio"/> BDY01 - MAX.VISITS HAVE BEEN MET FOR THIS SERVICE	<input type="radio"/> NCDE1 - PROCEDURE CODE MISSING OR INVALID
<input type="radio"/> BNC01 -NOT A COVERED BENEFIT	<input type="radio"/> NEX05 - OPERATIVE/PROCEDURE REPORT NEEDED
<input type="radio"/> NEX49 - PLACE OF SERVICE INCONSISTANT WITH AUTHORIZATION	<input type="radio"/> NINC - INCLUDED IN GLOBAL PROCEDURE OR PRICING ARRANGEMENT
<input type="radio"/> OTHER - ADMINISTRATIVE DENIALS	<input type="radio"/> NPC01 - NO PROFESSIONAL COMPONENT ALLOWABLE
	<input type="radio"/> OTHER - REIMBURSEMENT DENIALS

Please Provide Information Listed Below

Member Name: _____ Member Medical Record Number (MRN): _____ Date of Service: _____ Total Billed Amount in Question: _____ Claim Number(s): _____

Please Submit Appeal To:
Kaiser Foundation Health Plan of the Mid-Atlantic States
2101 E. Jefferson Street, 2nd Floor East
Rockville, MD 20852
ATTN: Provider Appeals
Phone Number: 1 (877) 806-7470
Fax Number: (301) 388-1698

CHECK LIST

(Please submit Appeal with Documents listed below)

FACILITY	PROFESSIONAL
<input type="radio"/> Detailed Appeal Letter or Appeal Filing Form. (If Appeal is submitted without Appeal Filing Form, the information listed below must be present: Reason for denial, member name & date of birth, medical record number, service dates and claim number(s)).	<input type="radio"/> Detailed Appeal Letter or Appeal Filing Form. (If Appeal is submitted without Appeal Filing Form, the information listed below must be present: Reason for denial, member name, medical record number, service dates and claim number(s)).
<input type="radio"/> Hospital Registration Sheet or Hospital Face Sheet	<input type="radio"/> Medical Records, Operative Procedure Reports, Radiology, Pathology Reports
<input type="radio"/> Complete Medical Records with Physician Orders	<input type="radio"/> Copy of Claim
<input type="radio"/> Copy of claim and Itemized Bill	<input type="radio"/> If applicable: Account Ledger and/or Screen Print-Out. (Timely Filing Denials)
<input type="radio"/> If applicable: Medicare Summary Notice (MSN)	<input type="radio"/> If applicable: Medicare Summary Notice (MSN)
<input type="radio"/> If applicable: Account Ledger and/or Screen Print-Out. (Timely Filing Denials)	<input type="radio"/> Other

INFORMATIONAL PURPOSES ONLY

Kaiser Permanente Health Plan Coverage Options	
HMO- Center-Based PCP	Kaiser Permanente Signature
HMO- Center or Network-Based PCP	Kaiser Permanente Select
2-Tier Point of Service (POS)	Kaiser Permanente Added Choice
3-Tier Point of Service	Kaiser Permanente Flexible Choice
EPO- Self-Funded	Kaiser Permanente Self-Funded
Medicare Cost	Kaiser Permanente Medicare Plus

Appropriate Appeal Submission Addresses:

Appeal Submission Address for Coverage Plans Listed Below:		
Signature, Select, Added-Choice and Medicare Plus: 2101 E. Jefferson Street Rockville, MD 20852 ATTN: Provider Appeals Unit Phone Number: 1(877)806-7470 Fax Number: (301)388-1698	Flexible Choice: P.O. Box 261130 Plano, TX 75026 ATTN: Appeals Phone Number: 1(800)392-8649	Self-Funded: P.O. Box 30547 Salt Lake City, UT 84130-0547 ATTN: Appeals Phone Number: 1(877)740-4117