KAISER PERMANENTE®
Provider Contracting & Network Management

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

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CHECK LIST
(Please submit Appeal with Documents listed below)

FACILITY	PROFESSIONAL
O 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)).	O 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)).
O Hospital Registration Sheet or Hospital Face Sheet	O Medical Records, Operative Procedure Reports, Radiology, Pathology Reports
O Complete Medical Records with Physician Orders	O Copy of Claim
O Copy of claim and Itemized Bill	O If applicable: Account Ledger and/or Screen Print-Out. (Timely Filing Denials)
O If applicable: Medicare Summary Notice (MSN)	O If applicable: Medicare Summary Notice (MSN)
O If applicable: Account Ledger and/or Screen Print-Out. (Timely Filing Denials)	O 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