PartnershipAdvantage (HMO SNP)

APPEAL & PAYMENT DISPUTE FORM

Please Return:

Partnership HealthPlan of California

Attention: Grievance Unit

4665 Business Center Drive

Fairfield, CA 94534

707-863-4425 Phone

NON-CONTRACTED PROVIDER

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination.

To appeal a claim denial, submit a written request within **60 calendar days** of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed Waiver of Liability form (see back page)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination.

A payment dispute may be filed when the provider disagrees with the amount paid, including issues related to bundling of services.

To dispute a claim denial, submit a written request within **120 calendar days** of the remittance notification date and include at a minimum*:*

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical records or documentation to support the dispute

All disputes must be mailed directly to:

Attn: Grievance Department

Partnership HealthPlan of California

4665 Business Center Drive

Fairfield, CA 94534

(707) 863-4425 phone

(707) 863-4306 fax

Select one of the following types that you would like to file: ☐ **Payment Dispute** ☐**Appeal**

Member Information

Member Name: _____ Member ID: _____

Date of Birth: _____

Claim Information

Claim #: _____ Date of Service _____

Original Claim Amount Billed: _____

Original Claim Amount Paid: _____

Provider of Service Information

Provider Name: _____

Description of Dispute:

_____

_____

_____

_____

Provider Information Submitting the Request

Name of the person completing this form_____

Job Title: _____

Contact telephone number: _____

Mailing address for resolution letters:

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Please note, a waiver of liability is required if submitting appeals for zero payment.

A waiver of liability is attached to the back of this form.

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4665 Business Center Drive
Fairfield, CA 94534

WAIVER OF LIABILITY STATEMENT

_____

Medicare/HIC Number

_____

Enrollee's Name

_____ _____

Provider **Dates of Service**

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HealthPlan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____ _____

Signature **Date**