myNEXUS

NON-PARTICIPATING **PROVIDER**
CLAIM APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant myNEXUS to re-evaluate its original decision.

- An appeal request must include the myNEXUS claim numbers and supporting documentation (e.g. complete copy of the medical records and claim appeal request form).
- An appeal request must be submitted within 90 days of original claim denial date.
- Complete one request form for each patient you are submitting for the appeal.
- Review of a claim does not guarantee a change in payment disposition.
- An acknowledgement letter will be sent to you within ten (10) calendar days upon receipt of the Appeal form.

Provider Information:

Provider Name: ____

Provider NPI #:____

Claim Information:

Member Name:______________________________ Claim Number(s):___________________________

Member Group & ID #:________________________ Date(s) of Service: ___________________________

Reason for Appeal:

Clerical Error – Not a true duplicate, incorrect or missing modifier, incorrect billed quantity, incorrect bill amount

Timely Filing – Claims with DOS submitted beyond the allowed days as outlined within providers contractual agreement.

Pricing – Incorrect payment or application of benefits

Eligibility – Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility.

Medical Policy – Appeal a denial for failure to obtain prior authorization (Supporting documentation required).

Other – Provide a detailed description.

Description of Claim Appeal:

Supplemental Documentation Attached:

Remittance Advice   Refund   Medical Records   Other (e.g. Timely filing Documentation)

Contact Information:

Requester:_____________________Phone #:_____________________Date:_______________

Email Address: ____________________________________

Please submit the completed form and attachments via secure email to:

claimappeals@myNEXUScare.com

Additional Narrative:

WAIVER OF LIABILITY STATEMENT

Claim #:

Enrollee's Name:	Member ID:
Provider:	Dates of Service:
Health Plan:	

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: