NEW JERSEY PIP POST-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	11. CITY	12. STATE	13. ZIP

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME
17. SPECIALTY	18. TAX ID #	19. NPI #
20. ADDRESS (No. Street)	21. CITY	22. STATE / 23. ZIP

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ *ORIGINAL BILL (HCFA/UB)
- ☐ *EXPLANATION OF BENEFIT/PAYMENT
- ☐ *APPEAL RATIONALE NARRATIVE
- ☐ APTP DECISION/RESPONSE
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ PEER REVIEW REPORT
- ☐ AUDIT REPORT
- ☐ NETWORK TERMINATION DOCUMENT
- ☐ PPO CONTRACT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe): _____

POST-SERVICE APPEAL ISSUES

30. EOB ID	31. TOTAL BILL REIMBURSEMENT	32. EXPECTED BILL REIMBURSEMENT	33. **BILL LEVEL APPEAL CODE(S) 1-10

34. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S

* Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only

** Indicates sections that should be completed using the letter(s)/number(s) that correspond to the reason codes on the back of this form

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39. SIGNATURE OF PROVIDER _____ 40. DATE _____

NEW JERSEY PIP POST-SERVICE APPEAL
REASON CODES

	BILL LEVEL APPEAL CODES		LINE LEVEL APPEAL CODES
1	Improper Deductible Applied	A	Improper Application of Fee Schedule Amount
2	Improper Co-pay Applied	B	Improper Application of Modifier Reduction
3	Improper Interest Applied	C	Improper Application of Multiple Reduction Calculation
4	Interest Due - Payment Not Made Timely	D	Improper Application of Daily Max Cap Calculation
5	Bill Processed Under Wrong Patient	E	Improper use of National Correct Coding (NCCI)
6	No Response To Bill Submitted Post 60 Days	F	Improper Application of U&C Amount
7	Improper Application of Coordination of Benefits	G	Improper Application of PPO Amount
8	Improper Use of PPO - Not Participating In Network	H	Improper Application of Pre-cert Penalty Co-pay
9	Improper Use of PPO - Terminated From Network	I	Improper Application of Voluntary Network Penalty Co-pay
10	Improper Denial Based on Coverage Investigation	J	Improper Application of Prospective Medical Necessity Denial
		K	Improper Application of Retrospective Medical Necessity Denial
		L	Improper Application of Bill Audit Reduction
		M	Improper Application of Medical Code Review Reduction
		N	Improper Application of Peer Review Reduction
		O	Improper Application of IME Reduction
		P	Improper Application of Missing Supportive Medical Records Denial
		Q	Improper Application of Coordination of Benefits
		R	Data Capture Error Caused Improper Reimbursement
		S	No Response to Services Billed

NEW JERSEY PIP PRE-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH

10. ADDRESS (No. Street)	11. CITY	12. STATE	13. ZIP

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME

17. SPECIALTY	18. TAX ID #	19. NPI #

20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ ***ORIGINAL APTP FORM**
- ☐ ***APTP DECISION/RESPONSE DOCUMENT**
- ☐ ***APPEAL RATIONALE NARRATIVE**
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ DIAGNOSTIC REPORT(S)
- ☐ PEER REVIEW REPORT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe): _____

PRE-SERVICE APPEAL ISSUES

30. DATE(S) OF REQUEST FROM → TO						31. CPT, HCPCS, NDC	32. RESPONSE NOT RECEIVED WITHIN 3 BUSINESS DAYS YES INDICATE WITH X	33. ADMINISTRATIVE DISPUTE YES INDICATE WITH X	34. MEDICAL NECESSITY DISPUTE YES INDICATE WITH X
MM	DD	YY	MM	DD	YY				

*** Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only**

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

35. SIGNATURE OF PROVIDER _____ 36. DATE _____