

STATE OF NEW JERSEY  
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE ESTABLISHMENT )  
OF UNIFORM PRE-SERVICE AND ) ORDER  
POST-SERVICE INTERNAL APPEAL FORMS )

This matter having been opened by the Commissioner of the Department of Banking and Insurance ("Commissioner") pursuant to the authority granted in N.J.S.A. 17:1-15, 17:1-15e, N.J.A.C. 11:3-4.7(d) and 11:3-4.7B, and all powers expressed or implied therein;

IT APPEARING that pursuant to N.J.S.A. 39:6A-3.1, 39:6A-4 and N.J.A.C. 11:3-4.7(c)5, insurers must file Decision Point Review Plans with the Department that include, "an internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or administration of a test;" and

IT FURTHER APPEARING that N.J.A.C. 11:3-4.7B sets forth the standards that all insurer internal appeal procedures must follow; and

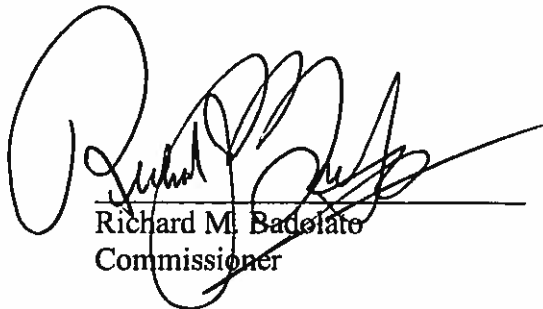
IT FURTHER APPEARING that N.J.A.C. 11:3-4.7B(c) states that all internal appeals shall be initiated using forms established by the Department; and

IT FURTHER APPEARING that forms developed by the Department have been distributed to representatives of the provider and insurer community for comment, and the Department has considered those comments; and

IT FURTHER APPEARING that pursuant to N.J.A.C. 11:3-4.7(d), the Commissioner may, by Order, mandate the use of uniform forms by insurers and providers;

THEREFORE IT IS on this 8th day of February, 2017 ORDERED that:

1. Effective April 17, 2017, the New Jersey PIP Pre-Service Appeal Form and the New Jersey PIP Post-Service Appeal Form, attached as Appendix A and B to this Order, shall be used by all providers to submit requests for internal appeals. Additional information and guidance on use of the forms shall be provided in a Frequently Asked Questions document available on the Department's website.

  
Richard M. Badolato  
Commissioner

# Appendix A

## 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
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### CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS
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### 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		28. PROVIDER AVAILABILITY TIME OF DAY:	
MONDAY	TUESDAY	WEDNESDAY	THURSDAY
FRIDAY	FROM		TO

### DOCUMENTS INCLUDED

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

<input type="checkbox"/> *ORIGINAL APTP FORM	<input type="checkbox"/> *APTP DECISION/RESPONSE DOCUMENT	<input type="checkbox"/> *APPEAL RATIONALE NARRATIVE
<input type="checkbox"/> INDEPENDENT MEDICAL EXAM REPORT	<input type="checkbox"/> DIAGNOSTIC REPORT(S)	<input type="checkbox"/> PEER REVIEW REPORT
<input type="checkbox"/> OTHER SUPPORTING DOCUMENTS (Describe): _____		

### PRE-SERVICE APPEAL ISSUES

30. DATE(S) OF REQUEST						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
FROM			TO						
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
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# Appendix B

## 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								
<b>CLAIM INFORMATION</b>														
3. INSURANCE COMPANY				4. CLAIM #			5. DATE OF LOSS							
<b>PATIENT INFORMATION</b>														
6. LAST NAME				7. FIRST NAME			8. MIDDLE INITIAL	9. DATE OF BIRTH						
10. ADDRESS (No. Street)				11. CITY			12. STATE	13. ZIP						
<b>PROVIDER/FACILITY INFORMATION</b>														
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: <table style="width: 100%; text-align: center; font-size: x-small;"> <tr> <td>MONDAY</td> <td>TUESDAY</td> <td>WEDNESDAY</td> <td>THURSDAY</td> <td>FRIDAY</td> </tr> </table>						MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM			TO
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY										
<b>DOCUMENTS INCLUDED</b>														
29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)														
<input type="checkbox"/> *ORIGINAL BILL (HCFA/UB)			<input type="checkbox"/> *EXPLANATION OF BENEFIT/PAYMENT			<input type="checkbox"/> *APPEAL RATIONALE NARRATIVE								
<input type="checkbox"/> APTP DECISION/RESPONSE			<input type="checkbox"/> INDEPENDENT MEDICAL EXAM REPORT			<input type="checkbox"/> PEER REVIEW REPORT								
<input type="checkbox"/> AUDIT REPORT			<input type="checkbox"/> NETWORK TERMINATION DOCUMENT			<input type="checkbox"/> PPO CONTRACT								
<input type="checkbox"/> OTHER SUPPORTING DOCUMENTS (Describe): _____														
<b>POST-SERVICE APPEAL ISSUES</b>														
30. EOB ID		31. TOTAL BILL REIMBURSEMENT			32. EXPECTED BILL REIMBURSEMENT			33. **BILL LEVEL APPEAL CODE(S) 1-10						
34. DATE(S) OF SERVICE						35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S					
FROM		→		TO										
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  
 \*\* 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 \_\_\_\_\_

Page 1 of 2 PIP Post-Service Appeal Form Version 1.2 (2/2017)

## 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