

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
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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 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): _____		

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		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
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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