VIII.B. Second Level Provider Claims Appeal – PHC Medi-Cal Claims Appeal (Medi-Cal Appeal Form)

The PHC Medi-Cal Claims Appeal process offers providers dissatisfied with the processing or payment of a claim, resubmission of a claim, or a claim inquiry, a method for resolving their dissatisfaction.

An Appeal may be submitted using the Medi-Cal Appeal Form (90-1). All Appeals must be signed. Each appeal may only include claims for one PHC member. Do not submit an appeal if the claim is still in a pended status.

Supporting Documentation:

Necessary documentation should be submitted with each appeal to allow for a thorough review of the appeal. It is very important that all supporting documentation be legible. Include applicable attachments such as:

* Claim copy, corrected if necessary
* Copy of PHC Remittance Advice (RA) Report
* Copy of POE printouts or Medi-Cal ID cards
* Copy of Medicare EOMB
* Copy of Other Coverage EOBs/RAs or denials
* Copy of all CIFs, Claims Inquiry letters, CIF Response Letters, or other dated correspondence to and from PHC to document timely follow-up
* Copy of TAR or RAF
* Copy of manufacturer's invoice or catalog page
* Copy of the PCP prescription
* Copy of report for "By Report" procedures
* Copy of completed Sterilization Consent Form

Appeal submission timelines:

CIF denials for timeliness cannot be appealed.

A provider may submit a "Claim Appeal" within 90 days of the CIF denial. Failure to submit an appeal within the 90-day time period will result in the appeal being denied. A claim which is submitted on appeal has already been reviewed and denied by PHC's Claims Department two separate times once on the original claim submission and once as the result of a CIF submission and/or a re-CIF. Appeals regarding RAF/TARs and non claim denials will be addressed through the PHC Provider Relations Department.

PHC will acknowledge an Appeal within 15 working days of receipt of the appeal and will respond with an Appeal Response Letter indicating the outcome of the appeal review within 45 working days. If the appealed claim is approved for adjustment, it will appear on a future RA. The claim will continue to be subject to claim processing criteria.

Verification of Timely Submission:

The only acceptable documentation to verify timely submission of a claim is a copy of an PHC RA, Claims Inquiry Acknowledgement (CIF), Claims Inquiry Response Letter, or any dated correspondence from PHC containing a CCN with a Julian date falling within the six-month billing limit for the claim submission. A copy of the CIF alone without the accompanying Claims Inquiry Acknowledgement/Response Letter does not prove timely follow-up when filing an appeal and may cause the appeal to be denied.

Submit all Appeals to:

Partnership HealthPlan of California
Attn: Claims Department/Appeals
P.O. Box 1368
Suisun City, CA 94585-1368

Instructions on completing the Appeal Form:

Each numbered item below refers to an area on the Medi-Cal Appeal Form shown on the previous page.

Item	Description
1.	*Appeal Reference Number.* For PHC use only.
2.	*Document Number.* The pre-imprinted number identifying the Appeal Form.
3.	*Provider Name/Address.* Enter the following information: Provider Name, Street Address, City, State, and ZIP code.
4.	*Provider Number* (Required Field). Enter your provider number/National Provider Identifier (NPI). Without the correct provider number, appeal acknowledgement may be delayed.
5.	*Claim Type*. Enter an "X" in the box indicating the claim type. Only one box may be checked.
6.	*Statement of Appeal.* For information purposes only.
7.	*Patient's Name.* Enter up to the first 10 letters of the patient's last name.
8.	*Patient's Medi-Cal ID number/SSN* (Required Field). Enter the recipient ID number that appears on the RA showing adjudication of that claim.
9.	*Delete.* Enter an "X" to delete the corresponding line.

10. *Claim Control Number* (Required Field if Appealing a Previously Adjudicated Claim). Enter the 12-digit number assigned by PHC to the claim in question. (This number is the Control number found on the PHC RA for the claim, plus the 4-digit number preceding each claim line).

11. *Date of Service.* In six-digit format (MMDDYY) enter the date the service was rendered. For block billed claims, you must enter the "from" date of service.

12. *EOB/RA Code.* When appealing a claim, enter the PHC Adj Rsn/Remark for the claim line (e.g., 45, N14, 96, 4).

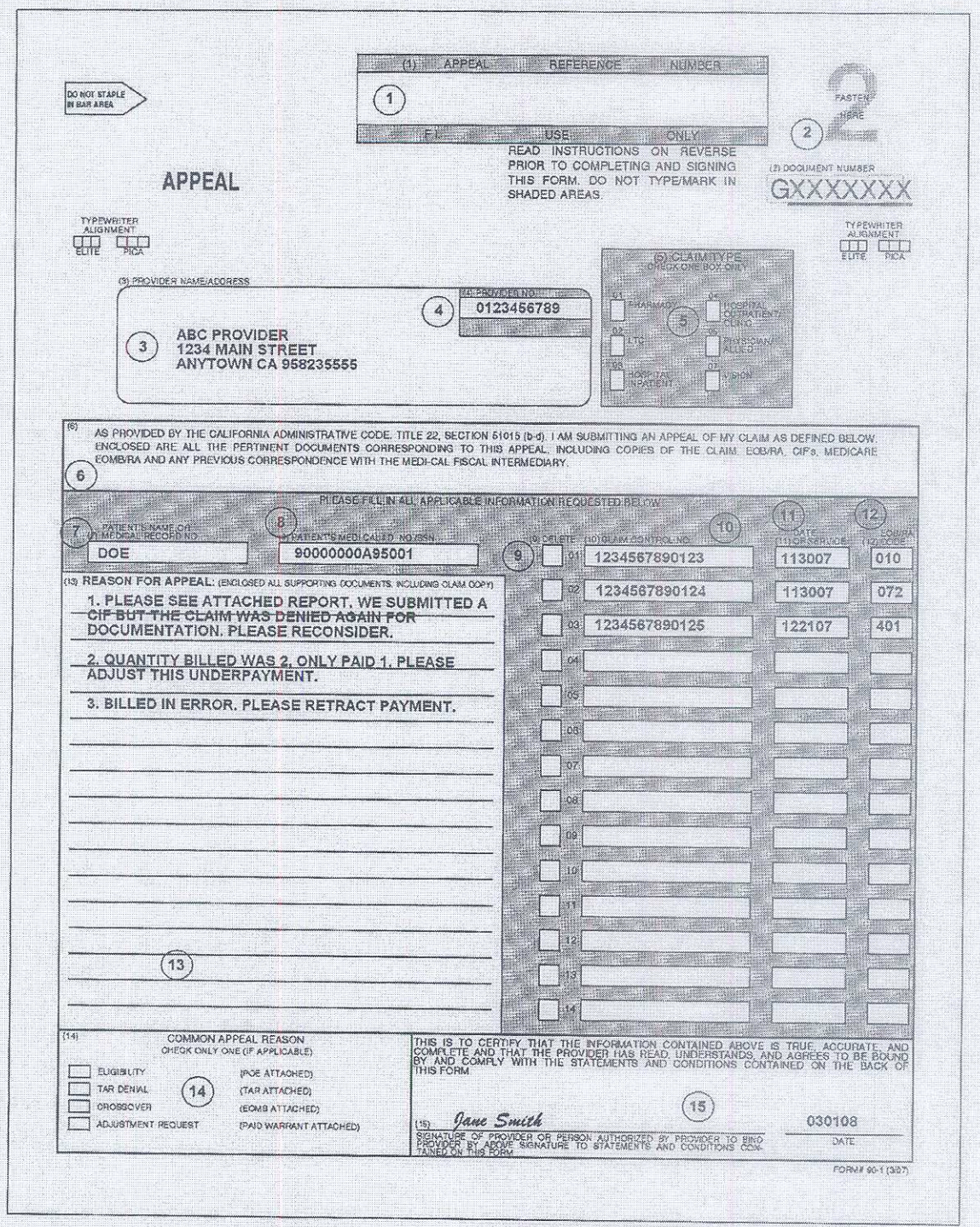
13. *Reason for Appeal.* Indicate your reason for filing an appeal. Be as specific as possible. In order for the examiners to properly research the complaint, all supporting documentation must be included.

14. *Common Appeal Reasons.* Check one of these boxes if applicable. Include a copy of the claim and supporting documentation (e.g., POE, TAR, EOMB). This box is for your convenience only. Leave Box 13 blank if this box is used.

15. *Signature.* This provider or an authorized representative must sign the Appeal Form.

A sample of the Medi-Cal Appeal form can be found on page 4 of this section.

For further information on how to complete a Medi-Cal Appeal form, please refer to the State of California Medi-Cal Provider Manual at www.medi-cal.ca.gov.



(1) APPEAL REFERENCE NUMBER: 1

DO NOT STAPLE IN BAR AREA

FASTEN HERE: 2

FI USE ONLY

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

APPEAL

(2) DOCUMENT NUMBER: GXXXXXXX

TYPEWRITER ALIGNMENT: ELITE PICA

(3) PROVIDER NAME/ADDRESS: 3
ABC PROVIDER
1234 MAIN STREET
ANYTOWN CA 958235555

(4) PROVIDER NO.: 4 — 0123456789

(5) CLAIM TYPE (CHECK ONE BOX ONLY): 5
01 PHARMACY
02 LTC
03 HOSPITAL INPATIENT
04 HOSPITAL OUTPATIENT/ CLINIC
05 PHYSICIAN/ ALLIED
07 D RNH

(6) AS PROVIDED BY THE CALIFORNIA ADMINISTRATIVE CODE, TITLE 22, SECTION 51015 (b-d), I AM SUBMITTING AN APPEAL OF MY CLAIM AS DEFINED BELOW. ENCLOSED ARE ALL THE PERTINENT DOCUMENTS CORRESPONDING TO THIS APPEAL, INCLUDING COPIES OF THE CLAIM, EOB/RA, CIF's, MEDICARE EOMB/RA AND ANY PREVIOUS CORRESPONDENCE WITH THE MEDI-CAL FISCAL INTERMEDIARY. 6

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(7) PATIENT'S NAME OR (7) MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL ID NO./SSN	(9) DELETE	(10) CLAIM CONTROL NO.	(11) DATE OF SERVICE	(12) EOB/RA TCN CODE
DOE	90000000A95001	01	1234567890123	113007	010
		02	1234567890124	113007	072
		03	1234567890125	122107	401
		04			
		05			
		06			
		07			
		08			
		09			
		10			
		11			
		12			
		13			
		14			

(13) REASON FOR APPEAL: (ENCLOSE ALL SUPPORTING DOCUMENTS, INCLUDING CLAIM COPY)

1. PLEASE SEE ATTACHED REPORT, WE SUBMITTED A CIF BUT THE CLAIM WAS DENIED AGAIN FOR DOCUMENTATION. PLEASE RECONSIDER.

2. QUANTITY BILLED WAS 2, ONLY PAID 1. PLEASE ADJUST THIS UNDERPAYMENT.

3. BILLED IN ERROR. PLEASE RETRACT PAYMENT.

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(14) COMMON APPEAL REASON
CHECK ONLY ONE (IF APPLICABLE)

- ☐ ELIGIBILITY (POE ATTACHED)
- ☐ TAR DENIAL (TAR ATTACHED)
- ☐ CROSSOVER (EOMB ATTACHED)
- ☐ ADJUSTMENT REQUEST (PAID WARRANT ATTACHED)

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THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

15

(15) Jane Smith
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM

030108
DATE

FORM# 90-1 (3/07)

Figure 1. Sample Completed *Appeal Form* (90-1): Denial Resubmissions, Underpayment Reconsiderations and Overpayment Returns.

2 – Appeal Form Completion

January 2008