Independent Health

PROVIDER INQUIRY FORM

Confidential

Please do not use this form for first time claim submissions including COB Claims with EOB's.

Today's Date _____ Provider Name: _____

NPI/ID Number: _____ Phone #: _____ Ext: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____ Contact Name: _____

Member Name: _____

Member ID#: _____ Acct #: _____

Date of Service_____ Claim Number_____

☐ Check here if the Contact Name and Billing Address listed above are a third party on behalf of the provider.

Please check at least one box below to ensure accurate handling of this request.

SECTION 1: Check one of the following to request:

☐ Retrospective adverse utilization review determination appeal** ☐ Provider appealing on behalf of the member**

☐ Post-service payment dispute where the member is not at financial risk

☐ Corrected claim* ☐ Timely filing issue ☐ Administrative sanction appeal**

For corrections please submit a CMS-1500 or UB-04 with **all services that were rendered.*

***Send to Benefit Administration as indicated below*

SECTION 2: Complete if requesting an adjustment related to coordination of benefits:

☐ Independent Health is primary ☐ Independent Health is secondary

SECTION 3: Indicate what supporting documentation is included:

☐ Medical records ☐ Manufacturer's invoice ☐ Proof of timely filing

☐ EOB/EOMB ☐ NDC Number ☐ Other (please add comments below)

PROVIDER COMMENTS: Include further explanation if necessary:

_____

_____

_____

_____

Please submit your inquiry to the appropriate address or email this form and attachments to provider-inquiries@independenthealth.com

Provider Inquiries:
Independent Health Provider Relations
P.O. Box 1017
Buffalo, NY 14231

COB Inquiries
Independent Health COB
P.O. Box 621
Buffalo, NY 14231

Benefit Administration
Independent Health Benefit Administration
P.O. Box 2090
Buffalo, NY 14231 or **fax to 716-635-3504**

Definitions

Retrospective adverse utilization review determination appeal: a determination by a utilization review agent that a health care service that has been provided is medically necessary. A provider has their own right to appeal a retrospective adverse determination rendered by a utilization review agent. This only applies to the Commercial and State lines of business. These appeals should be sent to Benefit Administration.

Provider appealing on behalf of the member: an appeal request where the provider is appealing on behalf of the member. The initial denial includes but is not limited to an Initial Adverse Determination, Notice of Denial of Medical Coverage, Notice of Denial of Payment, Notice of Denial of Medicare Part D Drug Coverage, or Explanation of Benefits. Reference the applicable appeal policy for written authorization requirements by line of business. These appeals should be sent to Benefit Administration.

Post-service payment dispute where the member is not at financial risk: participating provider disputing a claim denial or incorrect reimbursement amounts (except where that pertains to previously established fee schedules or other such fee arrangements that are negotiated pursuant to the provider's participating agreement) where the provider is responsible and the member is not at financial risk.

Administrative sanction appeal: appeal regarding financial sanctions imposed against a provider for violation of contract or policy, rule, regulation, or process. These appeals should be sent to Benefit Administration.