LDH Independent Review Request Form

Aggregated Claims Only

**** La-RS 46:460.81 Subject to approval by the department, a provider may aggregate multiple adverse determinations involving the same managed care organization when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The sole fact that a claim is not paid does not create a common substantive question of fact or law unless the provider received no remittance advice or other written or electronic notice from a managed care organization either partially or totally denying the claim within sixty calendar days of receipt of the claim by the managed care organization and the claims involve a common substantive question of fact or law.****

Please complete this form and mail it back to us. You will be copied on our correspondence concerning this matter. Please provide documentation that supports your complaint.

PROVIDER INFORMATION

Provider Name: Provider NPI:

Street Address:

City: State: Zip Code:

Phone Number: Fax Number:

Provider Representative: Email:

Provider Type:

☐ Physician ☐ Hospital ☐ Behavioral Health

☐ FQHC ☐ RHC ☐ Other

MCO INFORMATION

My complaint is against:

☐ Aetna Better Health ☐ Amerihealth Caritas ☐ Healthy Blue

☐ Louisiana Healthcare Connections ☐ United Healthcare

Are you an in-network provider with this MCO?

☐ Yes ☐ No

Explain if needed:

Type here.

AGGREGATED CLAIMS INFORMATION

NOTE: Claims being aggregated must have a common MCO and denial reason. Claims denied for the same reason by different MCOs cannot be aggregated.

Total Number of Claims:

Total Number of Enrollees:

Reason(s) for Complaint:

☐ Untimely Filing ☐ Claim recoupment error ☐ Claim paid incorrectly

☐ Medical Necessity ☐ Neither paid nor denied ☐ Lack of authorization

☐ Level of care ☐ Other:

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ENROLLEE/CLAIM INFORMATION

Complete this page for each case being submitted for independent review. Additional copies can be found at the end of this document.

Enrollee Name: Enrollee DOB:

Member ID:

Claim Number(s):

Beginning Date of Service: Ending Date of Service:

Total Amount Billed: Total Amount Paid:

Denied Date(s) of Service:

Date of Initial Claim Submission to MCO:

Date of Initial MCO Claim Denial or Recoupment:

Date Provider Submitted Written Reconsideration Request to MCO:

Date Provider Received Reconsideration Decision from MCO:

Please identify all supporting documents included in this submission for the case listed above by checking the appropriate boxes.

- ☐ Claim form, required
- ☐ Remittance advice, claim denial letter, and/or recoupment letter, required*
  - ☐ *Check this box if no remittance advice, claim denial letter, and/or recoupment letter was received from the MCO
- ☐ Independent review reconsideration submitted to MCO, required
- ☐ Independent review reconsideration determination letter, required*
  - ☐ *Check this box if no response was received from the MCO
- ☐ Authorization information, if applicable
- ☐ Appeal information, if applicable
- ☐ All correspondence from the MCO

DO NOT SEND MEDICAL RECORDS. The independent reviewer will request medical records from you.

Only claims which meet ALL requirements set forth in La-RS 46:460.81 are eligible for independent review. Claims payment disputes involved in litigation, arbitration or not associated with a MCO member are not eligible.

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SUPPORTING INFORMATION/DOCUMENTS

REQUIRED: Written description of the adverse determination.

Description may include, but is not limited to, the reason given for denial and your position explaining why the claims should have been paid.

Type here.

ACKNOWLEDGEMENT OF FEE OBLIGATION

By my signature below, I hereby request Independent Review of the above claim, pursuant to La-RS 46:460.81. I also confirm that the above-mentioned disputed claim will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer's fee. I also understand that there is a mandatory fee of $750.00 per claim and if I have a contract with the MCO, the MCO is initially responsible for paying the fee. I further understand that if the reviewer determines the MCO correctly denied payment of this disputed claim(s), then I must reimburse the MCO for the reviewer's fee as established by the selection panel for reviewers.

If you are not the aggrieved provider, what is your relationship to the provider?

Type here.

I declare that the information I have furnished is true and accurate.

Signature: **Date:**

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