THIRD PARTY PAYER REVIEW FORM

When AMCNO members or their office staff have specific practice management issues, questions or concerns with the numerous insurance carriers, the practice management department is always available to address or investigate these and other issues. This third party payer review form is a tool physician offices may utilize when specific issues/problems with an insurance carrier arise.

Physician's Name: ____ Specialty: ____

Address: ____

City: ______________________________ State: _________________________ Zip: _______________________________________

Phone: ____ Fax: ____________________________________

Contact Person: ____ Date Submitted: _________________________________

Name of insurance carrier: ____

Address of insurance carrier: ____

Telephone number of insurance carrier: ____

CPT code in question: ____________________________ Expected amount of reimbursement: ______________________________

Patient First Name Only: ______________________________ ***Insurance ID#: ____
(**Please do not include the patient's last name**)

Date of Service________________________________

Issue or Concern: (mark all that apply)

Types of Denials
Preauthorization
Referral
Claim

Payment Issues
Delay in payment
Late payment pattern
Pre/Post payment review

Claim Patterns
Down coding
Recording of claims
Lost claims
Data entry errors by insurer
Supporting documents missing
Pertinent claim information missing

Documentation Requests
Copy of medical record
Operative report

Telephone Access
Continuous busy signal
Excessive hold time
Numerous calls for a single claim
Other (specify) ____

Attach a letter describing the problem and detailing the sequence of events between your office and the insurance company. Also please attach copies of pertinent documentation including the claim, explanation of benefits, and any correspondence.

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IMPORTANT: Please do not send confidential patient information without the proper patient consent. Remove all identifying information, such as patient's last name, from documentation prior to submitting to AMCNO. ***All claims must have a numeric identifier as a form of identification. If the patient does not have an insurance identification number, use the primary policyholder's social security number or the patient's social security number. Please be advised that the AMCNO may share this information with the insurance carrier, relevant state agencies, or other parties to expedite resolution of your problem. The submission of this form and any attached information is consent to release this form and information, as appropriate, by the AMCNO. Please mail or fax this completed form to the **AMCNO, Practice Management Department, 6100 Oak Tree Blvd., #440, Cleveland, Ohio 44131 or fax 216.520.0999.** If you have any questions regarding this form and its use or additional issues or concerns, please contact the practice management department at 216.520.1000 or e-mail amcnocommunity@amcno.org