Provider Claim Inquiry Appeal Form Instructions

MedCost Benefit Services is responsible for resolving provider **benefit** claim denial appeals. Providers must use the Provider Claim Inquiry Appeal Form for provider **benefit** appeals to be accepted for MedCost Benefit Services products. All providers should use this form to submit provider **benefit** appeal requests on their own behalf.

To be valid for review, the form must be completed in its entirety, with all applicable fields filled (unless noted if applicable or optional). Incomplete forms will be deemed invalid for review.

In addition to a completed form, you must include the following information with a cover letter:

Office Contact Name - The person listed as the office contact should be able to answer questions about the appeal and provide additional records.
Office Contact Information – Valid email address, phone number and/or fax number.
Supporting Documentation – Explanation of your request stating *see attached*.

Providers can use the Provider Claim Inquiry Form to submit a provider **benefit** claim appeal to MedCost Benefit Services on their own behalf for the following claim denials:

Medical Necessity ***(Post Service Claim Denials Only):***

- Not Medically Necessary
- Cosmetic Services
- Investigational/Experimental Services
- No Authorization for Inpatient Hospital Admission
- Timely Filing disputes

Providers must submit a claim appeal to **Zelis Claims Cost Solutions** on their own behalf for the following **claim editing/coding denials:**

Billing and Editing/Coding Disputes:

- Integral Part of Primary Service
- Mutually Exclusive
- Services Not Eligible for Separate Reimbursement
- Incidental Denial
- Surgical Global Period Denial
- Re-bundling

Zelis Claims Cost Solutions
Attn: Inquiries Department
2 Crossroads Drive
Bedminster, NJ 07921
appeals.integrity@zelis.com
Fax: 855-787-2677

Important notice - Claims **editing/coding** appeals must be submitted directly to Zelis and will not be accepted by MedCost Benefit Services. Claims editing appeal inquiries misdirected will not be reviewed, processed or forwarded.

Provider Claim Inquiry Appeal Form

MEDCOST®

INSTRUCTIONS

- Include this form with a cover letter including valid email and fax number contact information.
- Use this form to request a review of a previously adjudicated claim.
- Submit only ***one form per member.***
- New or corrected claims should be submitted directly to the plan electronically or by mail if you are not an electronic biller. Faxed claims are not accepted.
- Incomplete inquiries received without the required information will not be reviewed or processed.

***Indicates a required field**

FOR PROVIDER USE ONLY

To help expedite your review, please complete this form in its entirety.

PLEASE MAIL ALL INQUIRIES TO:
MedCost Benefit Services Attention: Benefit Appeals
PO Box 25987
Winston-Salem, NC 27114

Please Fax to:
336-774-4420

PROVIDER INFORMATION

*PROVIDER NAME	
*PROVIDER MAILING ADDRESS	
*CITY/STATE	*ZIP CODE
*INDIVIDUAL NPI NUMBER	*GROUP NPI NUMBER

CLINICAL INFORMATION

*CLAIM NUMBER
*TOTAL CHARGE
*TO-DATE OF SERVICE
*FROM-DATE OF SERVICE

PATIENT INFORMATION

*PATIENT NAME	*PATIENT DATE OF BIRTH
*SUBSCRIBER ID WITH ALPHA PREFIX	PATIENT GROUP NUMBER

*TYPE OF REVIEW

(You must select one of the following reasons for inquiry.)

Please note: To ensure compliance with the Paperwork Reduction Act (44 U.S.C. 3501 et seq.), we are limiting our record requests to the minimum required. However, if the requested information does not support reimbursement for the claim, please send any additional information necessary to support the claim as originally submitted.

The reason for this inquiry is:

☐ **Claim(s) Inquiry**

- ☐ Original claim denied for timely filing (proof of timely filing attached)
- ☐ Original claim denied or closed for "coordination of benefits"
- ☐ Original claim denied for no authorization but valid authorization on file
- ☐ Claim denied as duplicate to a previously finalized claim
- ☐ Original claim denied no coverage
- ☐ Newborn added to policy, original claim denied
- ☐ Incorrect member name/ID billed on previously submitted claim
- ☐ Incorrect copay/coinsurance applied benefit quoted was not received
- ☐ Overpayment/underpayment due to another payer (COB)
- ☐ Contractual allowance dispute (fee schedule documentation required)

☐ **Medical Records** - Reconsideration of a ***previously adjudicated*** claim related to:

- ☐ Medical necessity
- ☐ Potentially cosmetic, experimental or investigational services

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