

NHP/NHIC ~ Provider Dispute Process Policy

Purpose: This policy outlines NHP/NHIC's process for handling provider disputes.

Policy and Procedure: If a provider disputes the processing of claims; they should first contact NHP/NHIC's Customer Service Department for assistance at (920) 720-1300 or (800) 826-0940. If the provider still disputes NHP/NHIC's decision after working with Customer Service a written dispute notice should be submitted to:

Network Health Plan/Network Health Insurance Corporation
Attn: Provider Disputes
P.O. Box 120
Menasha, WI 54952

To initiate a dispute, providers must submit their request in writing. The dispute must be received by NHP/NHIC within 180 calendar days from the date of the provider's remittance advice. Dispute requests received after 180 calendar days from the date of the provider's remittance advice will not be considered by NHP/NHIC.

To complete a provider dispute please include the following information:

- Provider's name, Provider Tax identification number, and Provider contact information.
- Patient name, Patient identification information, Date(s) of service, and Claim total billed amount.
- A copy of the original claim and remittance advice, if applicable.
- Clear and concise explanation of the reason for the dispute.
- Attach supporting documentation such as medical records, operative notes and/or detailed CPT coding information if the dispute is due to procedure code bundling and/or procedure modifiers.
- If the claim was denied for no pre-certification or referral, please attach documentation that supports a pre-certification referral was obtained prior to the service or procedure being rendered.
- If the appeal is in regards to untimely filing; please reference the Timely Filing Guidelines.

NHP/NHIC will review the dispute and render a determination within 45 business days of receipt of the original NHP/NHIC dispute. If the original processing determination is overturned, the claim will be reprocessed within the next

processing cycle and the Remittance Advice will serve as notice of the determination. If the determination is upheld, NHP/NHIC will send a letter to the provider with the notice of our decision and applicable information related to our decision.

When a provider dispute is submitted on behalf of a member it will be handled according to the NHP/NHIC member grievance process, not the provider dispute resolution process.

This policy is not a guarantee of coverage or payment. The claim(s) will be denied if it does not meet with all the terms and provisions of the members Certificate of Coverage. Actual benefits will be determined when the claim(s) or bill(s) are submitted to NHP/NHIC. NHP/NHIC reserves the right to periodically review and update all claims policies and procedures.

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