Health Net HEALTH PLAN OF OREGON

Health Net LIFE INSURANCE COMPANY

PROVIDER DISPUTE REQUEST SUMMARY AND FORM

Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company, Inc. (Health Net) strives to informally resolve issues raised on initial contact whenever possible. If an issue involves a partial payment or payment denial and cannot be resolved by Health Net's Customer Contact Center associates, Health Net offers its providers a two-level internal dispute and appeal process.

Dispute Process

All supporting documentation submitted is reviewed along with the terms of the member's benefit plan and the Health Net *Provider Participation Agreement* (*PPA*) and its requirements. After reviewing all documentation, Health Net makes a determination regarding the provider's dispute request. If the provider is not satisfied with the review decision, he or she may request an appeal.

Step 1: Contact Health Net's Provider Services team at 1-888-445-8913 (Medicare) or 1-888-802-7001 (commercial) to review any denial or payment reductions. If a Provider Services associate is unable to resolve the issue to the provider's satisfaction, the provider will be advised of their right to dispute the decision.

Step 2: The provider may ask the Provider Services associate to forward his or her dispute, or he or she may prepare a written dispute and submit it to the appropriate address indicated in this document. Providers may also submit an unlimited number of verbal disputes over the phone with a Provider Services representative. Disputes may also be submitted via the Medicare provider portal, at provider.healthnetoregon.com, using the "messaging" feature. Complete and accurate preparation of the request facilitates a timely and thorough review.

Requests for review, whether written or verbal, must include:

- A completed Provider Dispute Request Form requesting review of the payment decision, along with additional information as appropriate, to support the description of the dispute.
- For reviews with a clinical component, such as denied hospital days or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable.
- It is not necessary to include a copy of a claim previously processed, but include a copy of the remittance advice (RA) whenever possible.
- Per the Health Net PPA, disputes must be submitted within 365 days of the date the claim was denied or payment intended to satisfy the claim was made.

Step 3: Submit requests for disputes to the following addresses:

Medicare Provider Disputes
PO Box 9030
Farmington, MO 63640-9030

Commercial Provider Disputes
PO Box 9040
Farmington, MO 63640-9040

Step 4: If a determination is made to alter the initial decision and an additional payment is to be issued, providers are notified of the payment adjustment via the RA. If a decision is made to uphold the initial determination, providers are notified via a written response. Providers not satisfied with Health Net's decision may request an appeal. The provider appeal process is located in the operations manuals in the Provider Library.

Nonparticipating providers

For Medicare Advantage nonparticipating providers, when submitting an appeal on behalf of the member, the established Centers for Medicare & Medicaid Services (CMS) process must be followed and a completed Appointment of Representative (AOR) form must be included. When submitting a provider appeal, include a Confidential Communication Request (Waiver Liability) form, which is available in the Provider Library under Forms.

Please note: nonparticipating providers for commercial products have no appeal opportunities unless they are appealing on behalf of the member. If a nonparticipating provider is dissatisfied with a payment or nonpayment decision, only the member has the right to appeal by following Health Net's member grievance and appeal procedure.

PROVIDER DISPUTE REQUEST FORM

Date (mm/dd/yyyy):_______________________

Requestor Information		
Provider name:		
Provider # or Tax ID:		
Contact name:	Signature:	
Telephone:	Fax:	
Address:		
City:	State:	ZIP Code:

Claim Information
Member name:
Member ID #:
Claim number(s):
Date(s) of service:
Billed amount:
Process date:

Action Requested (Please include a copy of the remittance advice, corrected claim(s) and chart notes if necessary).		
☐ Authorization #	☐ Billed/allowed amount (attach copy of manufacturer's invoice)*	
☐ COB	☐ Date of service	☐ Denied as duplicate
☐ Diagnosis code*	☐ Number of units	☐ Member responsibility*
☐ Place of service*	☐ Procedure code/modifier*	☐ Other
Narrative describing disputed payment:		

*May require information that substantiates the request; for example, statement from the physician, operative report, office notes, or supporting medical documentation.

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