75 Sam Fonzo Drive · Beverly, Massachusetts 01915 · 800.227.2757 · ElectricInsurance.com

DATE

«PersonName_To»
«Address_Claimant»

RE: «PersonName_Claimant»
Claim #:«Claim Number»
DOL: «DateLoss»

«Dear»

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses as the result of a motor vehicle accident. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm.

The Automobile Policy of Insurance and Electric Insurance Company®'s Decision Point Review /Pre-Certification Plan contain **VERY IMPORTANT INFORMATION ABOUT YOUR NO-FAULT COVERAGE WITH ELECTRIC INSURANCE**. You and any health care provider with whom you seek medically necessary treatment, diagnostic testing, and/or durable medical equipment are responsible for following the requirements set forth in the Automobile Policy of Insurance and Electric Insurance's Decision Point Review /Pre-Certification Plan if reimbursement for tests and treatment is sought. A portion of the relevant Decision Point Review/Pre-Certification Pan is included herein.

Consolidated Services Group, Inc. (**CSG**) has been selected by Electric Insurance as its PIP Vendor to implement their plan as required by the Automobile Cost Reduction Act. CSG will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services. A copy of informational materials approved by the New Jersey Department of Banking and Insurance is available through CSG's website at www.csg-inc.net.

The Plan Administrator of this plan is:

CSG, Inc.
300 American Metro Blvd
Suite 170
Hamilton, NJ 08619

Phone Number:	877.258.2378
Fax Number:	856.910.2501
Website	www.csg-inc.net

If certain medically necessary services are performed without notifying Electric Insurance or CSG a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-certification. Such treatment (within the first 10 days) shall be subject to retrospective review, as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification

Your treating provider should complete the attached "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to CSG by fax (856.910.2501), or mail (300 American Metro Blvd., Suite 170 Hamilton, NJ 08619 Attn: Pre-Certification Department). This form can be accessed on the DOBI website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or CSG's web site at www.csg-inc.net. Any questions regarding your treatment request can be directed to CSG at 877.258.2378 during regular business hours of Monday through Friday 7:00 AM to 7:00 PM, EST except for Federally and/or State Declared Holidays and/or New Jersey declared "State of Emergencies" related to inclement weather where travel is prohibited.

Decision Point Review

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, known as Care Paths, for soft tissue injuries, collectively referred to as Identified Injuries. Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. *Decision Points* are intervals within the Care Paths where treatment is evaluated for a decision about the continuation or choice of further treatment the attending physician provides. At Decision Points, the eligible injured person or the health care provider must provide CSG with information regarding further treatment the health care provider intends to provide.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests, which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

Pre-Certification

Pursuant to N.J.A.C. 11:3-4, Pre-Certification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion Therapy
- Extended Care Rehabilitation Facilities
- All Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Path's.
- All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with decision point review.
- All Outpatient psychological/psychiatric treatment/testing and/or services

- All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
- Home Health Care
- Acupuncture
- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $75.00
- Non-Emergency Dental Restorations
- Temporo-mandibular disorders; any oral facial syndrome
- Current Perception Testing
- Nutritional Supplements
- All treatment and testing related to balance disorders
- Bone Scans
- Podiatry
- Any and all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code

Decision Point Review/Pre-Certification Process

On behalf of Electric Insurance, CSG will review all treatment plan requests and medical documentation submitted. A decision will be rendered within three business days after the receipt of a completed Attending Provider treatment Plan form request with supporting medical documentation. The Decision Point Review will be completed within 3 business days of receipt of the necessary information and notice of the decision will be communicated to the requesting medical provider by telephone and/or confirmed in writing. Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

If additional information is requested, the decision will be rendered within three days of our receipt of the additional information. In the event that Electric Insurance or CSG does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received. If a decision is not rendered within three business days of receipt of an "Attending Provider Treatment Plan " form, the treating health care provider, may render medically necessary treatment until a decision is rendered.

Failure to request decision point review or pre-certification where required, or failure to provide clinically supported findings that support the treatment, test, or durable medical equipment requested, shall result in an additional co-payment of 50% of the eligible charge for medically necessary: (1) diagnostic tests; (2) treatments; or (3) durable medical goods that were rendered/provided between the time notification to CSG was required and when CSG communicates the decision three (3) business days after the receipt of the treatment request. Such treatment shall be subject to retrospective review, as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary or reasonable.

In accordance with Order Number A16-101, all treating providers are required to submit all requests on the "Attending Provider Treatment Plan" for Decision Point Review and Precertification treatment requests. A copy of this form can be found on the NJ DOBI web site http://www.state.nj.us/dobi/pipinfo/aicrapg.htm **or at CSG's web site www.csg-inc.net.**

Providers who submit Decision Point Review/Precertification are those providers who, in part, physically and personally perform evaluations of the injured person's condition, state the specific treatment and set treatment goals. Electric Insurance will not accept Decision Point Review/Precertification requests from the following providers:

- Hospitals
- Radiologic Facilities
- Durable Medical Equipment Companies

- Ambulatory Surgery Centers
- Registered bio-analytical laboratories;
- Licensed health maintenance organizations
- Transportation Companies
- Suppliers of prescription drugs/pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request CSG will respond to that submitting provider no later than three business days after the request informing them that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

As it relates to this Decision Point Review Plan, the follow applies when "Days" are referenced:

- "Days" means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included.
- The last day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Example: Response on Decision Point Review and Precertification Requests must be communicated to the treating provider no later than three business days after the submitted request. A provider submits a proper request at Monday at 8:00 PM, which is 1 hour after the close of business hours at 7:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Example: Decisions on treatment appeals shall be communicated to the provider no later than 14 calendar days from the date the insurer receives the appeal. The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, January 5th. Day one of the 14- calendar day period is Wednesday, January 6th. The 14th calendar day would be Tuesday, January 19th, however there is a State of Emergency Declared in New Jersey on Tuesday January 19th due to inclement weather. The insurer's decision is due no later than Wednesday, January 20th, providing the State of Emergency has been lifted.

Decisions That May Be Communicated To You

Approved – A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Medical Director (if forwarded to a Medical Director Review) or as a result of an Independent Medical Examination.

Denied - A request for treatment/testing/Durable Medical Equipment is denied either by a Medical Director or an Independent Medical Examiner.

Modified- A request for treatment/testing/Durable Medical Equipment is modified either by a Medical Director or an Independent Medical Examiner.

Administrative Denial –Failure to submit "Attending Provider Treatment Plan" or an incomplete Decision Point Review and Precertification treatment request , including but not limited to an unauthorized provider, incomplete "Attending Provider Treatment Plan" and legible clinically supported record will result in the submitting provider being notified, within three business days of the incomplete submission of what is needed to complete the precertification submission Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three business days after the submission.

Retrospective DOS – If the request for treatment/testing/Durable Medical Equipment is for a Date of Service, which has already occurred, a decision of Retrospective DOS will be rendered.

Pended to IME: If based on the Medical Director's opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient location to the examinee is scheduled within 7 calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Please note that the denial of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Voluntary Pre-Certification

We encourage you to participate in a voluntary pre-certification process by bringing a treatment plan request form to your provider or have them contact us for all services requested. CSG will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills your provider submits, when consistent with the agreed plan, will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and CSG to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

Independent Medical Examinations

CSG or Electric Insurance may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request by the treating provider. This examination will be scheduled with a provider in the same discipline as the treating provider and the most appropriate specialty related to the treating diagnoses, as well as at a location reasonably convenient to the injured person. CSG will schedule the appointment for the examination within 7 days of the day of the receipt of the request unless the insured/designee otherwise agrees to extend the time frame. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Such treatment shall be subject to retrospective review, as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary. Upon completion of the Independent Medical Examination, the treating provider will be notified of the results by fax or mail within three business days after the examination. A copy of the examiner's report is available upon request. If Electric Insurance or CSG fail to respond to the request within three business days of receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.

CSG will notify the injured party or designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments.

The following will constitute an unexcused failure:

1. Failure of the Injured Party to attend a scheduled IME without proper notice to CSG;
2. Failure of the Injured party to notify CSG at least two (2) days prior to the IME date;
3. Any reschedule of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from Electric Insurance;
4. Failure to provide requested medical records, including radiology films, at the time of the IME;
5. Failure to provide adequate proof of identification at the time of the IME; and/or
6. If the injured party that is being examined does not speak English, failure to request or provide an English speaking Interpreter for the exam.

If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or their designee, and all the providers treating the injured person for the diagnosis (and related diagnoses) contained in the attending physicians treatment plan form. This notification will place the injured person on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Network Services

CSG has established a network of approved vendors for diagnostic imaging studies for all MRI and CT scans, durable medical equipment with a cost or monthly rental over $75.00, prescription drugs, and all electro diagnostic testing listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except for needle EMGs, H-reflex, and nerve conduction velocity (NCV) tests performed

together by your treating provider. **Failure to use an approved vendor will result in an additional co-payment not to exceed 30 percent of the eligible charge.**

When one of the above listed services, tests or equipment is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the injured person or their designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred networks to obtain the medically necessary services, tests or equipment requested. In accordance with N.J.A.C. 11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30 percent of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, you may visit CSG's website at www.csg-inc.net, contact CSG by phone at 877.258.2378, via fax at 856.910.2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

When you are in need of *Prescription* Drugs a pharmacy card will be issued that can be presented at numerous participating pharmacies. Instructions on how to find a list of participating pharmacies will be included with the pharmacy card.

Penalty Notification

Failure to submit requests for Decision Point Review or Pre-certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co-payment is in addition to any co-payment stated in the insured's policy.

Assignment of Benefits

Health care providers that accept assignment for payment of benefits should be aware that they are required to hold harmless the injured person, insured or the insurance carrier for any reduction of benefits caused by the provider's failure to comply with the terms of the Decision Point Review /Pre-Certification Plan. In addition, your treating physician must agree to submit disputes to our Internal Appeals Process prior to submitting any disputes through National Arbitration Forum as per N.J.A.C. 11:3-5. **Failure to comply with the Decision Point Review /Pre-Certification Plan or the Requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy. Please note that any provider that has accepted an assignment of benefits, must comply with and complete the Appeals Process as noted below prior to initiating arbitration or litigation. Completing the appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.**

Internal Appeal Process (effective April 17, 2017)

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the NJ Department of Banking and Insurance. The minimum required information (identified by form section number) is as follows: KEY DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 9-13) PROVIDER/FACILITY INFO (sections 14-25) DOCUMENTS INCLUDED INFO (section 29 indicated with asterisk) PRE-SERVICE APPEALS ISSUES INFO (sections 30-31, and 32, 33, or 34) POST-SERVICE APPEALS ISSUES INFO (sections 30-31, 33 and/or 38 and 34-36 if completing section 38) PRE-SERVICE SIGNATURE INFO (sections 35-36) POST-SERVICE SIGNATURE INFO (sections 39-40). Failure to follow these requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission does not constitute acceptance within the required timeframes for Pre-service and Post-service appeals.

Failure to utilize the Internal Appeals procedures as outlined in 11:3-4.7B on the forms established by the Department prior to filing arbitration or litigation will invalidate any assignment of benefits.

There are two types of appeals (with specific workflows) that can be considered:

Pre-service: an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity.

The Pre-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.

Decisions on pre-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: Peer Review, Independent Medical Exam, Medical Director Review, etc…) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-service: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

The Post-service appeal form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 552-1999 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

Decisions on post-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc…) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

The appeal process described above provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement for that treatment.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

Please note that any provider that has accepted an Assignment of Benefits or any insured , must comply with the Appeals Process as noted below prior to initiating arbitration or litigations, otherwise the Assignment of Benefits will be deemed null and void.

Payments/Reimbursement

Electric Insurance will reimburse all eligible medically necessary services in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When provider fees are not noted in a fee schedule, Electric Insurance reserves the right to reimburse the appropriate fee schedule amount for a similar service or equipment in the region where the service or equipment was provided, or Electric Insurance will determine the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. National databases of fees, such as those published by FAIR Health (www.fairhealthus.org) or Wasserman (http://www.medfees.com/), for example, are evidence of the reasonableness of fees for the provider's geographic region or ZIP code. The use of national databases of fees is not limited to the above examples. Electric Insurance reserves the right to reimburse whichever amount is less.

Electric Insurance has no obligation to reimburse for specific CPT/HCPC codes if approved or pre-certified in a Decision Point Review/Precertification request as it relates to applying payment methodology in the NJ PIP regulations, including but not limited to the NCCI edits. If the NCCI edits prohibit reimbursement for the codes that were billed such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of Electric Insurance's obligation to only reimburse for medically necessary treatment. To obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/.

Dispute Resolution Process

If the treating provider is not satisfied with the results of CSG's Internal Appeals Process, the treating provider may file with the Dispute Resolution governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on the Forthright website, http://www.nj-no-fault.com. Electric Insurance retains the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unless emergent relief is sought, failure to utilize the Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

Should you have any questions or require any further information not available through the websites, do not hesitate to contact CSG or us. Electric Insurance's plan administrator, CSG, is available by phone at 877.258.2378, facsimile at 856.910.2501, or in writing at 300 American Metro Boulevard., Suite 170, Hamilton, NJ 08619.

Sincerely,

Electric Insurance Company

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

DATE SUBMITTED: Month | Day | Year

TYPE OR PRINT LEGIBLY | CLAIM #:

PATIENT INFORMATION

1. PATIENT'S NAME: Last | First | Initial
2. PATIENT'S ADDRESS (No. Street)
3. CITY | 4. STATE
5. ZIP CODE | 6. TELEPHONE # (Include Area Code)
7. PATIENT BIRTHDATE | 8. SEX ☐ M ☐ F
9. INSURANCE COMPANY
10. POLICY NUMBER

11. DATE OF ACCIDENT

12. IS PATIENT'S CONDITION RELATED TO:
A. EMPLOYMENT? ☐ YES ☐ NO
B. AUTO ACCIDENT? ☐ YES ☐ NO
C. OTHER ACCIDENT? ☐ YES ☐ NO

13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (If different)

14. POLICYHOLDER'S NAME: Last | First | Initial
15. POLICYHOLDER'S ADDRESS (No. Street)
16. CITY | 17. STATE
18. TELEPHONE # (Include Area Code) | 19. ZIP CODE
20. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

21. NAME OF TREATING PROVIDER: Last | First | Initial
22. TAX I.D. | 23. NPI | 24. SPECIALTY | 25. FACILITY OR OFFICE NAME
26. FACILITY /OFFICE ADDRESS (No. Street) | 27. CITY | 28. STATE | 29. ZIP CODE
30. TELEPHONE # (Include Area Code) | 31. EMAIL ADDRESS | 32.. FAX # (Include Area Code) | 33. INITIAL DATE OF TX | 34. DATE OF LAST VISIT

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ MEDICATIONS ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTIC TEST ☐ EXISTING CONDITIONS ☐ COMORBIDITIES ☐ OTHER

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (38C) ICD Ind. ☐ 9 ☐ 10

A. B. C. D.
E. F. G. H.
I. J. K. L.

37. CHECK APPROPRIATE CARE PATH (If applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

38. DATE(S) OF REQUEST FROM MM	DD	YY	TO MM	DD	YY	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT New	EQUIPMENT Rental	SPINAL INJECTION Unilateral	SPINAL INJECTION Bilateral	DIAGNOSIS POINTER	FREQUENCY (Times per Visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS

☐ INCLUDE SUPPORTING DOCUMENTS

FRAUD PREVENTION - NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39

SIGNATURE OF PROVIDER DATE

NEW JERSEY PIP POST-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	**11. CITY**	**12. STATE**	**13. ZIP**

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME
17. SPECIALTY	**18. TAX ID #**	**19. NPI #**

20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ ***ORIGINAL BILL (HCFA/UB)**
- ☐ ***EXPLANATION OF BENEFIT/PAYMENT**
- ☐ ***APPEAL RATIONALE NARRATIVE**
- ☐ APTP DECISION/RESPONSE
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ PEER REVIEW REPORT
- ☐ AUDIT REPORT
- ☐ NETWORK TERMINATION DOCUMENT
- ☐ PPO CONTRACT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe):

POST-SERVICE APPEAL ISSUES

30. EOB ID	31. TOTAL BILL REIMBURSEMENT	32. EXPECTED BILL REIMBURSEMENT	33. **BILL LEVEL APPEAL CODE(S) 1-10

34. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S

*** Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only**

**** Indicates sections that should be completed using the letter(s)/number(s) that correspond to the reason codes on the back of this form**

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39. SIGNATURE OF PROVIDER

40. DATE

NEW JERSEY PIP POST-SERVICE APPEAL
REASON CODES

	BILL LEVEL APPEAL CODES		LINE LEVEL APPEAL CODES
1	Improper Deductible Applied	A	Improper Application of Fee Schedule Amount
2	Improper Co-pay Applied	B	Improper Application of Modifier Reduction
3	Improper Interest Applied	C	Improper Application of Multiple Reduction Calculation
4	Interest Due - Payment Not Made Timely	D	Improper Application of Daily Max Cap Calculation
5	Bill Processed Under Wrong Patient	E	Improper use of National Correct Coding (NCCI)
6	No Response To Bill Submitted Post 60 Days	F	Improper Application of U&C Amount
7	Improper Application of Coordination of Benefits	G	Improper Application of PPO Amount
8	Improper Use of PPO - Not Participating In Network	H	Improper Application of Pre-cert Penalty Co-pay
9	Improper Use of PPO - Terminated From Network	I	Improper Application of Voluntary Network Penalty Co-pay
10	Improper Denial Based on Coverage Investigation	J	Improper Application of Prospective Medical Necessity Denial
		K	Improper Application of Retrospective Medical Necessity Denial
		L	Improper Application of Bill Audit Reduction
		M	Improper Application of Medical Code Review Reduction
		N	Improper Application of Peer Review Reduction
		O	Improper Application of IME Reduction
		P	Improper Application of Missing Supportive Medical Records Denial
		Q	Improper Application of Coordination of Benefits
		R	Data Capture Error Caused Improper Reimbursement
		S	No Response to Services Billed

NEW JERSEY PIP PRE-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH

10. ADDRESS (No. Street)	11. CITY	12. STATE	13. ZIP

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME

17. SPECIALTY	18. TAX ID #	19. NPI #

20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ *ORIGINAL APTP FORM
- ☐ *APTP DECISION/RESPONSE DOCUMENT
- ☐ *APPEAL RATIONALE NARRATIVE
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ DIAGNOSTIC REPORT(S)
- ☐ PEER REVIEW REPORT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe): _____

PRE-SERVICE APPEAL ISSUES

30. DATE(S) OF REQUEST FROM → TO						31. CPT, HCPCS, NDC	32. RESPONSE NOT RECEIVED WITHIN 3 BUSINESS DAYS YES INDICATE WITH X	33. ADMINISTRATIVE DISPUTE YES INDICATE WITH X	34. MEDICAL NECESSITY DISPUTE YES INDICATE WITH X
MM	DD	YY	MM	DD	YY				

* Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

35. SIGNATURE OF PROVIDER _____ 36. DATE _____