

## Informal Claim Dispute / Objection Form

(Level I Administrative and Claims Appeals)

### Applicability:

Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute / objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through 1-1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute /objection before you may file a formal appeal.

### Time Limits/ When to File:

The claim(s) in question must have originally been submitted to MHS in a timely manner:

- MHS contracted providers have 90 calendar days from date of service to file a claim
- Non-contracted providers have 365 calendar days from date of service to file a claim

The timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns, is waived.

*All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or appeal with MHS (effective March 1, 2021, 60 days).*

### What-to-file check list:

- ☐ This form or written request for informal claims dispute / objection resolution on your letterhead.
- ☐ Copies of original MHS EOP showing how the claim(s) in question were processed.
- ☐ Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
- ☐ Documentation of any previous attempt you have made to resolve the issue with MHS.
- ☐ Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim.
  - Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of timely submission.
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization requirements.
  - Documentation to support paying claims otherwise denied by coding or other audits.

All fields are required:

|                                                                                                                                                                                                                              |                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Provider Name:                                                                                                                                                                                                               | Member Name:            |
| Provider Tax ID#:                                                                                                                                                                                                            | Member (RID) Number:    |
| Requestor Name:                                                                                                                                                                                                              | Requestor Title:        |
| Date of this Request:                                                                                                                                                                                                        | Requestor Phone Number: |
| Claim Number(s):                                                                                                                                                                                                             | Date(s) of Service:     |
| Reason for Informal Claims Dispute / Objection, including why you think MHS should pay the claim(s), adjust or reconsider them and how the attached documentation supports your request. Attach additional sheets as needed: |                         |

### Where to File:

**Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Managed Health Services, Post Office Box 3000, Attn: Appeals Department, Farmington, MO 63640-3800**

MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days. If you do not receive a response within 30 calendar days, consider the original decision to have been upheld. At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal claim appeal (effective March 1, 2021, 60 days).