

## **SECTION L APPEALS**

### **PROVIDER CLAIM DISPUTES**

Phoenix Health Plan (PHP) encourages providers to contact Claims Customer Service at 602-824-3743 or 1-800-747-7997 for assistance with questions or concerns surrounding claim status, payment, partial payment, non-payment or payment reconsideration. A practitioner or provider may also dispute such matters by requesting a claim dispute.

All claim disputes submitted to PHP are investigated using applicable statutory, regulatory, contractual and policy provisions.

PHP encourages providers to submit a claim dispute in accordance with the AHCCCS guidelines by following the below steps:

#### **How to file a Claim Dispute:**

- A claim dispute may be filed:
  - Within 1 year from the date of service, or for a hospital inpatient claim, within 12 months of the date of discharge;
  - Within 1 year from the initial eligibility posting date; or
  - Within 60 days from the date of a remittance advice for a timely claim submission, *whichever is the greater of*.
- A PHP Claim Dispute form must be completed for each dispute. A claim dispute may also be submitted in writing by form of a letter. The letter must state in detail the factual and legal basis for the dispute along with the relief requested. Include a copy of the original filed claim along with all relevant supportive documentation (i.e. copy of original claim, operative report, medical records, electronic acceptance reports, etc.) with the request. PHP will not solicit missing documentation.
  - <http://www.phoenixhealthplan.com/pdf/Claims%20Dispute%20Web%20Form.pdf>
- The date of receipt by PHP is considered the date the claim dispute is filed.
- Submit claim disputes to the address below:

Phoenix Health Plan  
Attn: Provider Claim Disputes  
7878 North 16<sup>th</sup> Street, Suite 105  
Phoenix, AZ 85020  
Or FAX: 602-674-6673

#### **Upon receipt of your Claim Dispute**

- PHP acknowledges receipt of a dispute in writing, within 5 working days. The dispute is assigned a tracking number for future referrals or inquiry.
- The resolution of a claim dispute is communicated in writing and is delivered by mail or courier within 30 calendar days (or within 44 days if an extension is necessary).
- If a provider disagrees with PHP's resolution, the provider may file a request to elevate the matter to a State Fair Hearing.

## **SECTION L APPEALS**

### **State Fair Hearing**

- A request for a State Fair hearing is submitted to PHP within 30 days from the date of receipt of the claims dispute resolution letter. All information concerning the matter is forwarded to the AHCCCS Office of Administrative Legal Services who will schedule the matter for a hearing with an Administrative Law Judge. AHCCCS notifies the provider directly when the hearing has been scheduled.
- Submit requests for a State Fair Hearing to the address below:

Phoenix Health Plan  
Attn: Provider State Fair Hearing Requests  
7878 North 16<sup>th</sup> Street, Suite 105  
Phoenix, AZ 85020  
Or FAX to: 602-674-6673

All claim disputes are handled confidentially and documents relating to the dispute are filed in a secure area and maintained for 10 years.

### **MEMBER APPEALS**

Members may appeal actions taken by the health plan to deny, reduce, suspend, or terminate a service.

- An appeal may be filed orally or in writing within 60 days of the adverse action. A provider may file a standard or expedited appeal on behalf of the member only with the member's written consent. A standard appeal is resolved within 30 days of receipt of the appeal, or within 44 days when an extension is necessary. An expedited appeal may be filed when a provider attests that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or retain maximum function. The expedited appeal are resolved within 3 working days from the date of receipt of the appeal or within 17 calendar days when an extension is taken.
- Appeals may be filed to:

Phoenix Health Plan  
Attn: Member Appeals  
7878 North 16<sup>th</sup> Street, Suite 105  
Phoenix, AZ 85020  
Phone: 602-824-3735  
Or FAX to: 602-674-6673



# Phoenix Health Plan

*An Affiliate of Abrazo Health Care*

## PROVIDER CLAIM DISPUTE FORM

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**Arizona Revised Statute § 36-2903.01 (B)(4) AND Arizona Administrative Code R9-34-405 state in part:**

All claim disputes (i.e. complete or partial denial of a claim) must be submitted in writing within 12 months from the date of service (or the date of discharge for an inpatient claim) or within 60 days of the last adverse action, whichever is greater.

**Claim Dispute requests must include:**

1. A completed Claim Dispute Form **OR** a letter detailing the factual and legal basis for your dispute (please use one form for each disputed claim);
2. A copy of original claim and remittance advice;
3. Disputes with a clinical component (such as denied inpatient days, services denied for lack of medical necessity, claims denied for lack of prior authorization, etc.) should include a narrative describing the relief requested and all relevant medical records;
4. Mail the completed form(s) and documentation to:

**Claim Disputes  
Phoenix Health Plan  
7878 N. 16<sup>th</sup> St. #105  
Phoenix, AZ 85020**

Your dispute will be acknowledged within five (5) working days. You will receive a written Notice of Claim Dispute Resolution explaining our decision within thirty (30) calendar days. PHP may request an extension of up to fourteen (14) additional days if necessary. Payment for approved disputes will also be displayed on the remittance advice. If you disagree with our resolution, you may request a hearing as per the guidelines in A.A.C. R9-22-405(D) or as indicated on the Notice of Claim Dispute Resolution.

**NOTE:**

**Disputes that fail to detail the facts of the case as well as the legal argument OR disputes submitted with incomplete information may be denied without further review. PHP will not attempt to solicit supporting documentation.**

**Provider Information:**

Date:	Provider / Group Requesting Review:		
Contact Name (First Name, Last Name):			Department:
Correspondence Address:			
Fax Number:		Phone Number:	

**Member Information:**

Member Name:	Date of Birth:	AHCCCS I.D.:
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**Claim Information:**

Claim / Form #:	Date of Service:				
Procedure Code(s) disputed:	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				

**Reason/Supporting Information for Reconsideration** Clinical Documentation Attached  Yes  No