Participating Provider Request for Commercial Members’ Claim(s) Review

When should you use the Claim(s) Review Request Form?

Participating providers may use the Claim(s) Review Request Form to:

- submit information we requested,
- request additional review of a claim,
- provide additional or corrected information, or
- file an appeal or complaint regarding a claim. For services rendered to New Jersey Commercial members, you must use the State of New Jersey’s Health Care Providers Application to Appeal a Claims Determination form. To obtain a form, go to www.state.nj.us/dobi. New claims must be submitted through normal channels and may not be submitted by using the Claim(s) Review Request Form.

How do you submit a request?

- Complete and submit a separate form for each claim or multiple claims involving the same issue. Keep a copy of the completed form for your records. Please fill in the “Claim information” section (Section I) completely and attach any supporting documentation. Ensure that the claim number is included on the form or that a copy of your Remittance Advice statement(s) is attached. You may obtain a copy of your Remittance Advice statement(s) on oxfordhealth.com. Log in as a provider or facility and check Claim status from the Transactions tab. On the Claim Line Detail screen, click on “Download Remittance Advice.” If you need help, call our Web Help Desk at 1-800-811-0881 to speak with a knowledgeable representative.

- In the “Reason for request” section (Section II), please mark the appropriate box that will indicate specifically what you are requesting us to review.

- Use the “Comments” section (Section III) to provide an explanation of the reason for your request. Please use this section to explain why we should make payment on your claim and include a detailed explanation of requests for changes to coding of claims procedure codes, diagnosis codes, Diagnosis Related Group (DRG), place of service codes, revenue codes and other information you would like us to consider.

If you have other documentation that may help us understand your request or better explain your situation, please attach these items.

Where should you send the form?

Please choose the appropriate address listed at the top of the Claim(s) Review Request Form that best reflects the type of request you are submitting. If you are submitting:

- additional information we requested, please send your request to the Oxford Corrected/Resubmitted Claims address.

- a corrected claim that we did not request, please send your request to the Inquiry address.

- a non-clinical related claim appeal on your own behalf, please send your request to the Provider Appeal address.

- an appeal on the member’s behalf, please send your request to the Member Appeal address.

Note: This option requires you to attach the member’s signed Member Authorization for a Designated Representative form. To obtain a form, go to oxfordhealth.com, click on the Tools & Resources tab and then on “Forms.”

Please remember to include any relevant attachments when you mail the form.

How will you receive a response to the form?

You will receive a written response to your submission within the time frame required by law. You will receive either a new Remittance Advice Statement or a letter from us.

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Submitting this Claim(s) Review Request Form

1. Complete one form per claim or multiple claims involving the same issue. Please do not submit new claims to be processed.

2. Attach a copy of your Remittance Advice statement, if available, as well as other information that may help us understand your request or dispute.

3. Mail this form along with attachments to the P.O. Box specified below. Please check the appropriate box and send to the correct address.

- **Additional Information Requested**
  - Oxford Corrected/Resubmitted Claims
  - P.O. Box 29137
  - Hot Springs, AR 71903

- **Inquiry**
  - Oxford Correspondence Department
  - P.O. Box 29135
  - Hot Springs, AR 71903

- **Provider Appeal**
  - Oxford Provider Appeals Department
  - P.O. Box 29136
  - Hot Springs, AR 71903

- **Member Appeal**
  - Oxford Member Appeals Department
  - P.O. Box 29134
  - Hot Springs, AR 71903

*If the issue involves 20 or more claims, please send your appeal or inquiry to: Oxford Provider Projects, P.O. Box 29130, Hot Springs, AR 71903

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**Section I: Claim information**

Provider Name: ____________________________

Patient Oxford ID Number(s): ____________________________

Oxford Provider ID Number: ____________________________

Patient Name(s): ____________________________

Office Contact Name: ____________________________

Office Contact Phone Number: ____________________________

Tax Identification: ____________________________

Date(s) of Services: ____/____/____ - ____/____/____

Claim ID Number(s): ____________________________

Procedure Code(s): ____________________________

Auth/Reference Number (if applicable): ____________________________

Adjustment Codes(s): ____________________________

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**Section II: Reason for request** (Check the appropriate box.)

- Attached is the requested additional information on the Remittance Advice statement. Please include a corrected claim or other information as requested. (Must be submitted to the “Additional Information Requested” mailbox as listed above.)

- Claim was originally submitted with incorrect information. Attached is a corrected claim that was not requested. (For corrected claims, please indicate what is being added, deleted or changed in the comment section below.)

- Submitting proof of timely filing. (Please attach valid proof of timely filing such as EDI Acceptance Report for electronic claim(s), notice from another insurance carrier that proves claim was timely, etc.)

- Claim is denied in error as a duplicate.

- Disputing reimbursement policy (e.g., payment amount, contract rate, bundling, global days, maximum frequency per date, etc. Please explain in Comments section below).

- Initiating a review on behalf of the member. **Please include the member’s signed Member Authorization for a Designated Representative form. To obtain a form, go to oxfordhealth.com, click on the Tools & Resources tab and then on “Forms.”

- Other: __________________________________________________________________________

Please submit this information to Inquiry or Provider Appeal mailboxes as listed above.

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**Section III: Comments** (Please provide additional comments to explain your request or dispute.)

Comments: ___________________________________________

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Name of submitter: ____________________________

Date form completed: ____/____/____