

Attention Non-contracted Medicare Providers

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. An appeal may be filed when a provider disagrees with a claim denial, a revised favorable organization determination, and/or payment issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

- _ A statement indicating factual or legal basis for appeal
- _ A signed Waiver of Liability form (you may obtain a copy by going to:

<https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html>)

- _ A copy of the original claim
- _ A copy of the remittance notice showing the claim denial
- _ Any additional information, clinical records or documentation

Mail the appeal request to the member's Health Plan address:

Aetna Health Plan Appeals & Grievance
Unit P.O. Box 16047
Lexington, KY 40512

Alignment Health Plan – Provider Appeal PO
Box 14010
Orange, CA 92863

Anthem Blue Cross Senior Appeal and Grievances
MS: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Blue Shield of California - Medicare Appeals & Grievances Department
P.O. Box 927
Woodland Hills, CA 91365-9856

Brand New Day Health Plan
P.O. Box 93122
Long Beach, CA 90809-3122

Health Net Medicare Programs Provider Service Department
P.O. Box 10406
Van Nuys, CA 91410-0406

Humana Inc. Appeals and Grievance Department
P.O. Box 14165
Lexington, KY 40512-4165

Inter Valley Health Plan
ATTN: Appeals & Grievance Department
P.O. Box 6002
Pomona, CA 91769-6002

Scan Non-Contracted Provider Appeal
P.O. Box 22698
Long Beach, CA 90801

United Healthcare – Provider Appeal

MS: CA124-0157
P.O. Box 6106
Cypress, CA 90630

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid, stating Medicare allowed amounts were not paid. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- _ A statement indicating factual or legal basis for the dispute
- _ A copy of the original claim
- _ A copy of the remittance notice showing the claim payment
- _ Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to **PromiseCare / Hemet Community Medical Group**.

If you have additional questions relating to a dispute decision made, you may contact us at:

Phone: (951) 791-1111

Fax: (888) 285-2546

Mail: 1545 W. Florida Ave, Hemet, CA 92543

Email: claimsdept@promisecare.com

If you do not agree with the dispute determination, you have the option to request a 2nd level Health Plan dispute review. Please send all dispute requests in writing, accompanied by all documentation to support your position, directly to the Provider Appeals and Disputes team by using the following address:

Aetna Health Plan Appeals & Grievance Unit
P.O. Box 16047
Lexington, KY 40512

Alignment Health Plan – Provider Appeal
PO Box 14010
Orange, CA 92863

Anthem Blue Cross Senior Appeal and Grievances
MS: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Blue Shield of California - Medicare Appeals & Grievances Department
P.O. Box 927
Woodland Hills, CA 91365-9856

Brand New Day Health Plan
P.O. Box 93122
Long Beach, CA 90809-3122

Health Net Medicare Programs Provider Service Department
P.O. Box 10406
Van Nuys, CA 91410-0406

Humana Inc. Appeals and Grievance Department

P.O. Box 14165
Lexington, KY 40512-4165

Inter Valley Health Plan
ATTN: Appeals & Grievance Department
P.O. Box 6002
Pomona, CA 91769-6002

Scan Non-Contracted Provider Appeal
P.O. Box 22698
Long Beach, CA 90801

The request for Health Plan dispute review must be received within 180 calendar days from the determination date of the initial dispute.