REQUEST FOR PEER REVIEW WITH REGARD TO
CLINICAL OR CODING MATTER-Part 1

TO: Pennsylvania Podiatric Medical Association
    PEER REVIEW COMMITTEE

Please copy and use this form as a guide for gathering all the necessary information about your insurance complaint, and to help determine your next best step in the resolution process.

Personal Data:

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Suffix</th>
<th>Degree</th>
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<th>Office Street Address</th>
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<tr>
<td>City</td>
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| Telephone | Fax | E-mail |

| APMA Member # |

Please print or type all information and FAX to 1-1717-761-4091
In the event this FAX is received at the incorrect destination, the receiving party is asked to notify the sender immediately, and then destroy the FAXed information. THANK YOU.
HEALTH PLAN: ____________________________________________________________

PLAN TYPE:

( ) PPO  ( ) HMO  ( ) POS  ( ) Indemnity  ( ) Workers’ Comp

( ) Medicare  ( ) ERISA/Self-Funded  ( ) Other

TYPE OF COMPLAINT (check all that apply):

☐ Denial of Referral
☐ Denial of Care
☐ Denial of Pre-Authorization
☐ Denial of Payment after Pre-Authorization
☐ Denial of CPT Modifier
☐ Incorrect Application of CPT Modifier
☐ Incorrect or Partial Payment (per contracted fee schedule)
☐ Coordination of Benefit Issue
☐ Lost Claims by Payer
☐ All-Products Clause
☐ Request for Extensive Documentation
☐ Late Payments
☐ Continuous Medical Review Referrals
☐ Non-Itemized Explanation of Benefits
☐ Payment Below Contract Schedule
☐ Payment at Different Rates Than MD/DOs
☐ Failure to List Membership in Plan Directory; Listing of Podiatrist in Section Apart from MD/DOs
☐ Inappropriate Modification of Originally Submitted CPT Code
☐ Inappropriate Down-coding of Originally Submitted CPT Code
☐ Inappropriate Bundling of Services/Procedures
☐ Denial of Procedure, Service, or Test CPT Code; Item/Supply HCPCS Code
☐ Failure to Follow General CPT Guidelines/CMS Guidelines
☐ Failure to Send Requested Payer Guidelines
☐ Automatic Denial of Code(s)
☐ Incorrect Re-Coding of Procedure/Service
☐ Other ____________________________________________________________

____________________________________________________________________________
____________________________________________________________________________
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( ) Check Here if additional space is required, and continue on a separate sheet.
Brief description of complaint, codes (original, modified, bundled), etc. Please include: 1) a copy of date of service medical record; 2) explanation of benefit with the claim clearly evident including the denial reason; and 3) a copy of the claim.

______________________________________________________________________________

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______________________________________________________________________________

( ) Check Here if additional space is required, and continue on a separate sheet.

CONTACTS MADE

Have you contacted:

( ) The Payer in Question?

( ) Your State Podiatric Medical Association?

( ) Your State Department of Insurance?

( ) Department of Consumer Affairs?

( ) Other:

______________________________________________________________________________

______________________________________________________________________________

Please include a copy of any sent and received correspondence.

Is this case in review by any of the above contacts?    ___Yes    ___No

( ) Check here if additional space is required, and continue on a separate sheet.

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