SEAVIEW IPA
1901 N. SOLAR DR., SUITE 265
OXNARD, CA 93036
805-988-2280

MEDICARE ADVANTAGE PLAN
NON-CONTRACTED PROVIDER PAYMENT APPEAL PROCESS

You have the right to appeal the denial of payment made by the health plan by initiating the Medicare Managed Care Beneficiary Appeals Process. This process is applicable to Medicare Advantage Plans if:

- You do not have a contract with the health plan to participate in their Medicare Advantage (MA) plans ("non-contracted provider") AND
- You received zero payment for services you provided to a health plan member enrolled in a MA HMO health plan.

The Centers for Medicare and Medicaid Services ("CMS") describes the Medicare Appeal Process available to non-contracted providers ("provider-as-party") in Section 60.1.1 of Chapter 13 of the *Medicare Managed Care Manual*, which is titled "Non-Contracted Provider Appeals".

Section 60.1.1 of Chapter 13 of the *Medicare Managed Care Manual* states:

> A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contracted provider completes a waiver of liability statement, which provides that the non-contracted provider will not bill the enrollee regardless of the outcome of the appeal.

Use the following copy of the Provider Waiver of Liability form"or" you may obtain a copy by going to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html, at the bottom of the page under the "Downloads" section select the zip file for 'Model Waiver of Liability_Feb2019v508'. Please note that the Provider Waiver Liability form must be completed in its entirety. The Medicare Health Insurance Claim Number (HICN) must be included on the Provider Waiver of Liability form. For more information on HICNs, please refer to Section 50.2 of Chapter 2 of the *Medicare Managed Care Manual*, titled "Medicare General Information, Eligibility, and Entitlement Manual". You can also find this manual on the CMS website at http://www.cms.gov/Manuals/IOM/list.asp.

Also include the following documents:

1. The original claim;
2. A copy of the denial letter with member liability if applicable;
3. A copy of your RA or EOB and;
4. The reason for the denial, including any supporting documents.

Additionally, your request for an appeal must be submitted in writing and be signed by the initiator. Please send your written request for an appeal to the health plan the member is enrolled with:

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Aetna Medicare Plan (HMO) Medicare Appeals & Grievances PO Box 14067 Lexington, KY 40512 Fax: 866-604-7092 Phone: 800-282-5366	Anthem Blue Cross Mailstop: OH0204-A537 4361 Irwin Simpson Rd Mason, OH 45040 Fax: 888-458-1406 Phone: 888-230-7338	Blue Shield 65 Plus HMO PO Box 927 6300 Canoga Ave. Woodland Hills, CA 91365-9856 Fax: 916-350-6510 Phone: 800-776-4466	Central Health Medicare Plan Appeals & Grievances Department 1540 Bridgegate Dr. Mail Stop 3000 Diamond Bar, CA 91765 Phone: 1-866-314-2427
Health Net of California, Inc. Medicare Appeals & Grievances PO Box 10406 Van Nuys, CA 91410-0406 Fax: 877-713-6189 Phone: 800-275-4737	SCAN Health Plan PO Box 22698 Long Beach, CA 90801 Phone: 1-800-307-8003	United Healthcare Appeals & Grievances Department Mail Stop CA 124-0157 PO Box 6106 Cypress, CA 90630 Fax: 888-517-7113 Phone: 800-234-1228	WellCare Health Plans, Inc. Appeals Department PO Box 31368 Tampa, FL 33631-3368 Fax: 866-201-0657 Phone: 866-999-3645
Golden State Medicare Health Plan Appeals & Grievances Department 3030 Old Ranch Parkway STE 155 Seal Beach, CA 90740 Fax: 562-799-0507 Phone: 877-541-4111	Humana Grievances & Appeals Department PO Box 14165 Lexington, KY 40512-4165 Fax: 800-949-2961 Phone: 800-867-6601	GEMCare Health Plan Appeals & Grievances Department 4550 California Avenue, Ste. 100 Bakersfield, CA 93309 Fax: 661-716-4810 Phone: 877-744-2709	Alignment Health Plan Appeals & Grievances Department 1100 W Town and Country Road Suite 1600 Orange, CA 92868 Fax: 323-201-5690 Phone: 1-866-634-2247

Please provide all appropriate documentation to support your payment appeal (e.g., remittance advice from a Medicare carrier). You must submit your request for payment appeal to health plan no later than 60 days form the date of the denial notice.

The health plan will review your payment appeal and respond to you. The health plan response will be within 60 days from the time your request for an appeal and signed Provider Waiver of Liability form is received by the health plan.

If the health plan finds in your favor, payment will be made at the applicable Medicare rate directly to you. If the health plan does not find fully in your favor, per the Medicare Appeal Process, your case will be forwarded to MAXIMUS Federal Services, Inc. MAXIMUS Federal Services, Inc. is an independent review entity contracted with the Centers for Medicare and Medicaid Services for an external review. You will receive written notification of the decision directly from MAXIMUS Federal Services, Inc.

If the decision is not in your favor, you will be advised regarding further appeal rights.

If you request an appeal and you did not include a Provider Waiver of Liability form, the health plan will notify you of this missing information. You must provide the health plan with a completed and signed Provider Waiver of Liability form before they proceed with reviewing your request for an appeal. If the Provider Waiver of Liability is not received within 60 calendar days of the health plan's receipt of your appeal request, per the *Medicare Managed Care Manual*, Chapter 13, Section 60.1.1, your request for an appeal will be sent to MAXIMUS Federal Services, Inc. for dismissal. You will receive written notification of the dismissal directly from MAXIMUS Federal Services, Inc.

If you have questions regarding the appeal process, please contact the Provider Service Center at the corresponding health plan.

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WAIVER OF LIABILITY STATEMENT
(For non-contracted provider Medicare Advantage claim appeals only)

Enrollee's Name

Enrollee ID Number

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date