**Attn: Banner–University Care, Banner Medicare Advantage and AARP United Medicare Complete Providers:**

There is a possibility that you may have received a remittance advice during the CHC Cyberattack that did not include the standard appeals language. Attached is information to assist you with appeals.

**Banner Medicare Advantage Providers:**

**Your rights if you disagree with our processing of your claim:**

Non-Contracted Providers may submit a post-payment reconsideration if the provider completes a waiver of liability (WOL), which ensures the non-contracted provider will not bill the enrollee regardless of the appeal outcome. All appeals must be submitted in writing and received by Banner Medicare Advantage within sixty (60) days of receipt of the remittance notification. Along with the WOL, non-contracted providers must submit documentation that supports their appeal (copy of original claim, claim records, etc.).

WOL can be found in the "Downloads" section online at: <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms>

Contracted Programs, unless otherwise provided for in contact, must submit a post-payment reconsideration within 60 days of this remittance advice.

Please ensure to submit claims for members with dual eligibility to the appropriate secondary payer. Please refer to AHCCCS Contractor Operations Manual (ACOM) 201 for Medicare Cost Sharing for Members Covered by Medicare and Medicaid.

Please mail reconsideration requests to:

Banner – Medicare Advantage

ATTN: Grievance & Appeals

5255 E Williams Circle, Ste 2050

Tucson, AZ 85711

Fax: (866) 873-0029

Resubmissions attempting to achieve clean claim status must be received within 12 months from the date of service, or 12 months from the date of eligibility posting, whichever is later and must include the words “resubmission” or “reconsideration.”

Please mail claims resubmissions to:

P.O. Box 38549

Phoenix, AZ 85069-7169

**Banner-University Family Care - AHCCCS Complete Care (ACC) Providers**

**Your rights if you disagree with our processing of your claim:**

Unless your contract states otherwise, in accordance with Arizona Revised Statutes (ARS) § 36.2903.01(B)(4), a grievance that is related to a claim for covered services (called “provider claim disputes”) must be filed in writing with B – UFC/ACC within 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

Provider Claim Disputes must be labeled as such and must include a formal cover letter providing the factual and legal basis for the dispute.

Please mail provider claim disputes to:

B – UFC/ACC

Attn: Grievances and Appeals Department
5255 E Williams Circle, Ste 2050
Tucson, AZ 85711

If you need to correct your claim, please submit a corrected claim rather than filing a provider claim dispute.

Please mail claims resubmissions to:

P.O. Box 35699

Phoenix, AZ 85069

**Banner-University Family Care - Arizona Long Term Care System (ALTCS) Providers:**

**Your rights if you disagree with our processing of your claim:**

Unless your contract states otherwise, in accordance with Arizona Revised Statutes (ARS) § 36.2903.01(B)(4), a grievance that is related to a claim for covered services (called “provider claim disputes”) must be filed in writing with B – UFC/ALTCS within 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

Provider Claim Disputes must be labeled as such and must include a formal cover letter providing the factual and legal basis for the dispute.

Please mail provider claim disputes to:

B-UFC/ALTCS

Attn: Grievances and Appeals Department
5255 E Williams Circle, Ste 2050
Tucson, AZ 85711

If you need to correct your claim, please submit a corrected claim rather than filing a provider claim dispute.

Please mail claims resubmissions to:

P.O. Box 37279

Phoenix, AZ 85069

**United Healthcare/BPN Providers:**

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 including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 60 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/downloads/model-waiver-of-liability_feb2019v508.zip>
* 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:

UnitedHealthcare

P.O. Box 6106, Cypress, CA 90630

MS:CA124-0 157.

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the Plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare. 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

Contracted Providers

When disputing a claim payment for any reason (i.e., denial, underpayment, etc.), the provider must submit the request to BHN Reimbursement Services to:

Attn: BHN Reimbursement Services Provider Payment Disputes

AARP United Medicare Complete

PO BOX 16423

Mesa, AZ 85211

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

Phone: 480-684-7070 Toll free 1-800-827-2464

Mail: Banner Health PO Box 16423 Mesa, AZ 85211-6423

Email: ProviderExperienceCenter@bannerhealth.com

Billing Alerts

Section 190S(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without there Medicaid coverage, or someone receiving Supplemental Security Income benefits and Medicare for the Medicare deductible or coinsurance.