NEW JERSEY PIP PRE-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	**11. CITY**	**12. STATE**	**13. ZIP**

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME
17. SPECIALTY	**18. TAX ID #**	**19. NPI #**
20. ADDRESS (No. Street)	**21. CITY**	**22. STATE** / **23. ZIP**

24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS

27. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

- ☐ ***ORIGINAL APTP FORM**
- ☐ ***APTP DECISION/RESPONSE DOCUMENT**
- ☐ ***APPEAL RATIONALE NARRATIVE**
- ☐ INDEPENDENT MEDICAL EXAM REPORT
- ☐ DIAGNOSTIC REPORT(S)
- ☐ PEER REVIEW REPORT
- ☐ OTHER SUPPORTING DOCUMENTS (Describe): _____

PRE-SERVICE APPEAL ISSUES

30. DATE(**S**) OF REQUEST **FROM** → **TO**						31. CPT, HCPCS, NDC	32. RESPONSE NOT RECEIVED WITHIN 3 BUSINESS DAYS YES INDICATE WITH **X**	33. ADMINISTRATIVE DISPUTE YES INDICATE WITH **X**	34. MEDICAL NECESSITY DISPUTE YES INDICATE WITH **X**
MM	DD	YY	MM	DD	YY				
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*** Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only**

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

35. SIGNATURE OF PROVIDER _____ 36. DATE _____