

Negotiation Request Form

For New Jersey Out-of-Network Providers Only

This form is to be completed by physicians, hospitals or other health care professionals.

NOTE:

- Please submit a separate form for each request.
- No new claims should be submitted with this form.
- Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.

You may verify the member’s address using the eligibility search function on the website listed on the member’s health plan ID card.

Physician Hospital Other Health Care Professional (Lab, etc.)

Member Information

Date Form Completed _____

Member ID	Control/Claim Number	Date of Service		Billed Amount
Member Last Name		First Name		MI
Street Address		City	State	ZIP
Patient: Last Name		First Name		MI

Physician/Health Care Professional Information

Tax Identification Number (TIN) _____ Phone Number (with area code) _____

Email Address _____

Physician or other Health Care Professional Name (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB))

Last Name _____ First _____ MI _____

Street Address _____ City _____ State _____ ZIP _____

Facility/Group Name _____ Contact Person _____

Contact Fax Number (with area code) _____

CONTINUED

Negotiation request under the New Jersey Out-of-Network Accountability Act.

Comments:

Requested Attachments:

- Copy of PRA or EOB.

You may have additional rights under individual state laws. Please review the provider website uhcprovider.com, if you need more information.



This form can be submitted by certified mail to the address found on the back of the members ID card or emailed to NJ_OutofNetwork@uhc.com.

