CLAIM DISPUTE REVIEW FORM INSTRUCTIONS

1) Before completing, save this form as a PDF on your local device. This form will need to be signed using the Electronic Signature. This feature will be disabled if saved improperly and may lead to delay in processing.

2) Open the document using Adobe Acrobat Reader
   a) You may have to right click to select this option.

   b) If you do not have Adobe Acrobat Reader downloaded on your device, please consult your agency's IT professional.

3) Complete the form and electronically sign the document.
   a) If the electronic signature does not appear on the saved form please submit a NJMHAPP ticket. Use Application Q&A as the category.

Division of Mental Health & Addiction Services
wellnessrecoveryprevention
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CLAIM DISPUTE REVIEW FORM

If a provider disputes the denial or reduction of a claim, a request for review may be submitted within 60 days of notice of the denial or reduction. This form must be completed in its entirety and, along with any additional documentation supporting the Provider's position that the claim was inappropriately denied or reduced, submitted via NJMHAPP ticket, selecting "Claim Dispute Review Request" in the drop-down menu.

AGENCY: **DATE:**

ADDRESS: **COUNTY:**

CONSUMER NAME: **NJMHAPP ID #:**

SPECIFIC CLAIM DENIED OR REDUCED:

CLAIM DATE FROM: **To:**

DESCRIPTION OF THE REASON THE PROVIDER BELIEVES THAT THE DENIAL OR REDUCTION OF THE CLAIM WAS INAPPROPRIATE:

AGENCY CONTACT SIGNATURE: _____ **TITLE:**

AGENCY CONTACT EMAIL:

Submit completed form via NJMHAPP ticket, selecting "Claim Dispute Review Request" in drop-down menu.
To expedite review, a copy of the notice from DMHAS showing the denial or payment reduction should be included.

DMHAS USE:

CLAIM DISPUTE STATUS UPON REVIEW WITH EXECUTIVE STAFF:

☐ **Approved** ☐ **Denied** ☐ **Additional Information Needed**

MH FFS Unit Regional Coordinator: _____

DMHAS Deputy Assistant Commissioner: _____