Appeals 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 65 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 appeals request directly to the appropriate Medicare Advantage Plan. DO NOT mail the appeal to Sharp Community Medical Group.

For more information regarding non-contracted provider appeals, please visit the health plan website listed below:

Wellcare By Health Net
Provider Appeal
PO Box 3060
Farmington, MO 63640-3822
www.healthnet.com

Sharp Health Plan
Attn: Provider Dispute Resolution
8520 Tech Way, Suite 200
San Diego, CA 92123
www.sharphealthplan.com

United Healthcare
MS: CA120-0360
PO Box 6106
Cypress CA 90630
www.uhc.com