

Notice of Intent to Appeal an Adverse UM Determination – Stage 2

Instructions

Please note that, when referencing the adverse UM determination made by a carrier, the reference includes adverse UM determinations made by a carrier's subcontractor on behalf of the carrier. However, for purposes of this form (NIA-2), only identify the carrier by name.

1. This form is to be sent to the address on record for the patient who signed the *Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims*.
 - a. If the *Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims* form was signed on the patient's behalf by a Personal Representative, the NIA-2 should be sent to the address on record for the Personal Representative also, if different from the address of the patient.
 - b. The NIA-2 must be sent prior to the date that a Stage 2 UM Appeal is filed.
 - c. The NIA-2 should be sent by some method that allows for confirmation of delivery at the address on record.
2. The space between the title of the NIA-2 and the data table may be modified by the health care provider.
 - a. The health care provider must modify the NIA-2 to insert the health care provider's name.
 - b. The health care provider must modify the NIA-2 to insert the name of the patient, and the address on record for the patient.
 - c. The health care provider may modify the NIA-2 to add other identifying information about the patient and/or the patient's Personal Representative that the health care provider considers necessary for the health care provider's systems and that are not already included in the data table.
 - d. The health care provider may not modify the NIA-2 to include any logo for any party.
3. The data table fields should be completed as follows:
 - a. Insurance Carrier: insert the name of the insurance carrier to which the UM appeal is being made.
 - b. Ins. ID: insert the insurance identification number of the patient. If the patient has more than one insurance identification number on record, insert the insurance identification number issued by the insurance carrier to which the UM appeal is being made.
 - c. Claim No.: insert the claim identification number which resulted in the UM decision that is being appealed. If there is no known claim number, the field may be left blank, or information clearly indicating that the information is not applicable or unknown may be inserted.
 - d. Med. Record: insert the medical record number for the patient for the health care services that resulted in the adverse UM determination

- e. Service/Admission: insert the date of the health care service(s) or admission during which the health care services in question were rendered
 - f. Discharge: insert the date of discharge, if applicable. If there is no discharge date, or discharge has not yet occurred, the field may be left blank, or information clearly indicating that a date is not applicable or unknown may be inserted.
 - g. *Consent and Authorization*: insert the date the patient (or the Personal Representative) signed and dated the *Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims* on which the health care provider is relying to make the UM appeal.
 - h. UM Determination: insert the date of the adverse UM determination being appealed (this may be the date of denial of a precertification or preauthorization request, date of a remittance advice document, date of a claim denial, or date of an Explanation of Benefits, whichever event occurs first that provides notice that the health care services in question are or were not medically necessary).
 - i. Stage 1 Notice of Intent to Appeal: insert the date you issued the NIA-1.
 - j. Stage 1 Decision: insert the date on the Stage 1 UM appeal determination letter.
4. Insert the name of the patient in the field following "Dear."
5. At the end of the letter, insert sign-off language appropriate for your offices. You may insert additional information here that you may believe appropriate for your operational needs only. Do not insert any logos, other advisory information, or extraneous information.