AUTO INSURANCE UTILIZATION REVIEW PROVIDER APPEAL REQUEST

Submit Appeal Request to:
DIFS-URAppeals@michigan.gov

For guidance on filing an appeal, please reference ***The Health Care Provider's Guide to Michigan's Auto Insurance Utilization Review Appeals Process*** at www.michigan.gov/AutoInsuranceUR.

I. PROVIDER INFORMATION

The name of the provider entered below must match the provider's name listed on the determination or bill denial. All fields must be fully completed.

Provider (name of physician, hospital, clinic, or other person/entity):	
Provider Point of Contact (First and Last Name):	
Provider Mailing Address:	
Phone Number:	
Email Address:	
NPI:	
Date of Accident:	Injured Person Name and Mailing Address:
Claim Number:	
Has the provider previously filed a UR appeal involving the same injured person? No ☐ Yes ☐ If yes, please provide the assigned UR case number(s).	

II. AUTO INSURANCE COMPANY INFORMATION

Please provide the complete name of the auto insurance company related to this appeal request.

Auto Insurance Company Name:

III. APPEAL INFORMATION

Please enter the **Date of Determination/Denial (DOD)** with its corresponding **dates of service and procedure codes** that are being appealed. Do not include dates of service or codes that are **not** being appealed. *If additional space is needed, you may submit them as an attachment, using the same format.*

	DOD (MM/DD/YYYY)	Date(s) of Service	Procedure Code(s)
1			
2			
3			
4			
5			

IV. SUPPORTING DOCUMENTATION

The following documentation is **REQUIRED**. Failure to include all the documentation listed below will result in the rejection of your appeal request. DIFS may request additional documentation after your appeal has been filed.

☐ A detailed narrative explaining the reason for your appeal request and desired outcome.

☐ All pages of each determination/denial (e.g., Explanation of Benefits, Explanation of Review, etc.).

☐ All supporting documentation and medical records related to your appeal request.

☐ For appeals involving a dispute over the amount of reimbursement, a copy of your charge description master in effect on January 1, 2019, or, if you do not have a charge description master, the average amount charged for the service on January 1, 2019.

☐ For appeals involving a dispute over the amount of reimbursement, a completed FIS 2376 Auto Insurance Utilization Review Provider Attestation.

V. PROVIDER CERTIFICATION AND ACKNOWLEDGEMENTS

By signing this form, I understand and acknowledge that I will respond to the Michigan Department of Insurance and Financial Services' inquiries regarding this appeal, and I certify that the information included on this form is correct and complete to the best of my knowledge and belief. I also understand and acknowledge that submitting false or misleading information is cause for rejection of the appeal and may subject me and/or the provider to penalties as provided by law.

Authorized Signature:	Date:
Printed Name / Title:	Email Address: