

AUTO INSURANCE UTILIZATION REVIEW PROVIDER APPEAL REQUEST

Michigan Department of Insurance and Financial Services
Office of Appeals and Market Regulation
Utilization Review Section
Submit appeal request to: DIFS-URAppeals@michigan.gov

DIFS' utilization review (UR) section can only accept provider appeal requests involving disputes between auto insurers and providers related to the utilization or cost of an injured person's treatment, training, products, services, or accommodations. To be considered timely, an appeal to DIFS meeting these criteria must be filed with DIFS within 90 days of the date of the insurer's disputed determination or bill denial. For additional guidance on filing an appeal with DIFS UR, please reference ***The Health Care Provider's Guide to Michigan's Auto Insurance Utilization Review Appeals Process*** at www.michigan.gov/AutoInsuranceUR.

I. TYPE OF APPEAL (please check as applicable)

- Medical Necessity (must complete Sections I, II, III, IV, V, VII, and X)
- Cost (must complete Sections I, II, III, IV, V, VI, VIII or IX, and X)
- Both (must complete all Sections, I-VII, VIII or IX, and X)

II. PROVIDER INFORMATION

The name of the provider entered below must match the provider's name listed on the determination or bill denial. All fields are required and 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:	Ext.
Email Address:	
NPI:	
Have you previously filed a UR appeal involving the same injured person? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, please provide the assigned UR case number(s).	

III. INJURED PERSON INFORMATION

Injured Person's Name (First and Last):



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Previous Legal Name (N/A if not applicable):
Mailing Address:
Date of Accident:

IV. AUTO INSURANCE COMPANY INFORMATION

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

Auto Insurance Company Name:
Insurance Claim Number:

V. 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. Do not list a date range unless services were rendered on all dates included in the range. *If additional space is needed, you may submit them as an attachment using the same format.*

	DOD (MM/DD/YYYY)	Date(s) of Service (MM/DD/YYYY)	Procedure Code(s) *Not Diagnosis Code(s)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			



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VI. LOCATION OF SERVICES

For appeals involving a cost dispute, please provide the ZIP code and county where the service(s) at issue were rendered.

ZIP code and county where the service(s) were rendered:	
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VII. MEDICAL NECESSITY DISPUTE: REQUIRED SUPPORTING DOCUMENTATION

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

- A detailed narrative containing the following information:
 - The reason for your appeal request and the desired outcome.
 - Why you believe the treatment(s)/service(s) at issue were appropriate based on medically accepted standards.
- All pages of each determination/denial (e.g., Explanation of Benefits, Explanation of Review, etc.). If the most recent determination is a reconsideration, all pages of the original determination/denial must also be included.
- The billing claim form for the service(s) at issue.
- All supporting documentation and medical records related to your appeal request.

VIII. COST DISPUTE FOR ACCIDENTS PRIOR TO JUNE 11, 2019: REQUIRED SUPPORTING DOCUMENTATION

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

- A detailed narrative containing the following information:
 - The reason for your appeal request and the desired outcome.
 - The amount you believe is owed for the treatment(s)/service(s) at issue.
- All pages of each determination/denial (e.g., Explanation of Benefits, Explanation of Review, etc.). If the most recent determination is a reconsideration, all pages of the original determination/denial must also be included.
- The billing claim form for the service(s) in dispute.

IX. COST DISPUTE FOR ACCIDENTS ON OR AFTER JUNE 11, 2019: REQUIRED SUPPORTING DOCUMENTATION

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



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- A detailed narrative containing the following information:
 - The reason for your appeal request and the desired outcome.
 - The amount you feel is owed for the treatment(s)/service(s) at issue.
- All pages of each determination/denial (e.g., Explanation of Benefits, Explanation of Review, etc.). If the most recent determination is a reconsideration, all pages of the original determination/denial must also be included.
- The billing claim form for the service(s) at issue.
- 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.
 - If the treatment, product, service, or accommodation was not offered on January 1, 2019, or, if the provider's business was not established on January 1, 2019, please include this information in the detailed narrative explaining the basis for the appeal request.
- A completed Auto Insurance Utilization Review Provider Attestation (FIS 2376).

X. 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 non-acceptance 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:



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