AUTO INSURANCE UTILIZATION REVIEW PROVIDER APPEAL REQUEST

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Utilization Review Section
DIFS-URAppeals@michigan.gov
Fax: 517-763-0305
Michigan.gov/AutoInsuranceUR

For guidance on auto insurance utilization review appeals, 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 name listed on the insurer determination letter or insurer bill denial.

Provider (name of physician, hospital, clinic, or other person/entity):	
Provider Point of Contact:	
Provider Address:	
Phone Number:	Fax Number:
Email Address:	

II. CLAIM INFORMATION

Please include the following information related to this appeal request.

Date of Denial/Determination:	Date of Accident:
Date(s) of Service:	Claim Number:
	Injured Person Name and Mailing Address:

III. INSURER INFORMATION

Please provide the complete name and contact information of the insurer or insurance company related to this appeal request.

Insurer Name:	Insurer Address:

IV. DOCUMENTATION REQUIRED

The following information is required. Failure to include all documentation relevant to this appeal may result in the appeal request being rejected.

☐ A detailed narrative of the reason(s) for the appeal request.

☐ A copy of the insurer's notice of determination or a denial of a bill per R 500.64(1)(3).

☐ All correspondence and documents related to a request for explanation exchanged between the provider and the insurer prior to this appeal request per R 500.63.

☐ All supporting documentation related to the appeal request.

List of documentation included with appeal request (Date/Title/Number of Pages):

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: