

**REIMBURSEMENT ADVOCACY PROGRAM
PHYSICIAN REQUEST FOR CLAIMS ASSISTANCE
ASSIGNMENT FORM**

TO: Santa Clara County Medical Association – Monterey County Medical Society
Attention: Sandie Becker
700 Empey Way
San Jose, CA 95128
Ph: (408) 998-8850 / (831) 455-1008 (Monterey County)
Email: sandie@sccma.org Fax: (408) 289-1064

Before you file a request for assistance with the SCCMA, you must have already appealed your claim denial and received results with the carrier using the appropriate appeal guidelines.

Please be aware that a copy of this Request for Assistance and other documentation submitted by you may be provided to the insurance company. By signing and dating this form, you authorize the Santa Clara County Medical Association to contact the insurance company on your behalf.

FROM:

Doctor: _____ Address: _____

Contact name: _____ Phone: _____ Fax: _____

Regarding Insurance Claim for:

Patient's Name _____

Subscriber's Name _____

Insurance Carrier _____

Are you a contracted provider with this insurance? Y__ N__

Note: If you are not contracted with this patient's insurance carrier, you the provider, have no appeal rights. The patient is ultimately responsible for payment.

Address/Phone _____

Employer _____

Date claim originally submitted _____ Amt. of Charge/s _____

Date claim appealed _____ (include appeal letter and response from carrier)

Briefly, describe your problem and the steps you have taken to resolve (use additional paper if needed):

IMPORTANT! Attach copy of claim form/s, appeal letter and response, chart notes, lab results (if applicable), op report, insurance ID card, EOB and all follow-up correspondence to or from the insurance company.

Physician Signature _____ Date _____