Negotiation Request Form

For New Jersey Out-of-Network Providers Only

This form is to be completed by New Jersey Non-Participating physicians, hospitals or other health care professionals.

NOTE:

- Please submit a separate form for each request.
- No new claims should be submitted with this form.
- Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.

☐ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, etc.)

Member Information

Date Form Completed _____

Member ID	Control/Claim Number	Date of Service		Billed Amount
Member Last Name		First Name		MI
Street Address		City	State	ZIP
Patient: Last Name		First Name		MI

Physician/Health Care Professional Information

Tax Identification Number (TIN) _____ Phone Number (with area code) _____

Email Address _____

Physician or other Health Care Professional Name (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB))

Last Name _____ First _____ MI ____

Street Address _____ City _____ State ____ ZIP _____

Facility/Group Name _____ Contact Person _____

Contact Fax Number (with area code) _____

CONTINUED

Reason for request:

☐ Negotiation request under the New Jersey Out of Network Accountability Act.

Comments:

_____

_____

_____

Requested Attachments:

- Copy of PRA or EOB.

You may have additional rights under individual state laws. Please review the provider website, **oxfordhealth.com,** if you need more information.

This form can be submitted by certified mail to:

Oxford Health Insurance
Attn: Appeals & Grievances
7440 Woodland Drive
Indianapolis, IN 46278

Or emailed to: **uhoappealsandgrievances@uhc.com.**

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