NEW YORK STATE | Department of Health | Medical Indemnity Fund

Request for Claim Review Form: Member Reimbursement

Requests for claim review must be received by NYMIF within 60 days of the claim denial/paid date.

NYMIF Enrollee Name: ____________________________________ Today's Date ____ / ____ / ____

NYMIF Enrollee ID: NYS ___________________________________

Name of Person(s) Submitting Request: ____

Signature of Person(s) Submitting Request: ____

Relationship to Enrollee: ____

Address of Person Requesting the Review:

Street Address: ____

City: ___________________ State: ___________ Zip Code: ________________

Phone: ___________________

Claim Denial/Paid Date: ____ / ____ / ____

Please indicate reason for claim review. Enter 'x' in one box, and/or provide comment below, to reflect purpose of review submission.

	Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received
	Corrected Claim: The previously processed claim (paid or denied) requires a correction (e.g., Unit of Service, Date of Service, Item, or service description change, etc.) Please specify the correction to be made. **Specify the correction to be made within 'Comments' section below**
	Duplicate Claim: The original reason for denial was due to a duplicate claim submission
	Filing Limit: The claim whose original reason for denial was untimely filing. Please provide evidence of due diligence in trying to meet timely filing.

	Pre-Certification/Notification or Prior-Authorization: The request is for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.	
	Request for additional information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (e.g., Proof of Payment/Receipt, Missing/Invalid General/Travel Reimbursement Form, Co-pay on provider letterhead, Proof of Appointment etc.)	
	Retraction of Payment: Requesting a retraction of entire payment or service line (e.g., Item returned, Service not performed, etc.)	
	Other: Please Specify	

Comments (Please print clearly below):

In addition to this form, what documents (if any) are you including?

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If you have questions regarding this review or would like the status, please call our Customer Service:
1-855-NYMIF33 (855-696-4333) and select Option 4

Send completed forms to NY_DOH_MIF@pcgus.com subject: NYMIF Claim Review ***or***
Mail to: **MIF c/o PCG**, P.O. Box 784 Greenland, NH 03840-0784