

# Claims Assistance Program- Submission Form

The Claims Assistance Program assists MSNJ members with payer issues. Please see [instructions](#) for further details.



**Please do not include any protected health information (PHI) in your submission.**

Practice Name:	
Physician Name:	
NPI Number:	
Tax Identification Number:	
Contact Name:	
Contact Email Address:	
Contact Phone Number:	
Payer at Issue:	
Date Issue Began:	
Amount at Issue:	

**Issue:** *(Please check all that apply.)*

<input type="checkbox"/>	Arbitration Assistance	<input type="checkbox"/>	Prior Authorization/ Medical Necessity
<input type="checkbox"/>	Audit	<input type="checkbox"/>	Recoupment
<input type="checkbox"/>	Claims Payment Denial/ Low Payment	<input type="checkbox"/>	Termination/ Participation Status
<input type="checkbox"/>	Other:		

**Issue Description:** *(Please do not include PHI. You may use additional sheets.)*

**Permissions:** *(Please check all that apply.)*

<input type="checkbox"/>	I give MSNJ permission to reach out to the payer regarding this issue.
<input type="checkbox"/>	I give MSNJ permission to reach out to the appropriate government agency regarding this issue.
<input type="checkbox"/>	I certify that the practice has attempted to resolve this issue with the payer.

Email this form to [ashiber@msnj.org](mailto:ashiber@msnj.org) or send to our secure fax at 609.896.1884.  
**Please do not include any protected health information (PHI) in your submission.**  
 This is benefit is available to MSNJ members only.