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.)*

☐	Arbitration Assistance	☐	Prior Authorization/ Medical Necessity
☐	Audit	☐	Recoupment
☐	Claims Payment Denial/ Low Payment	☐	Termination/ Participation Status
Other:			

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

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

☐	I give MSNJ permission to reach out to the payer regarding this issue.
☐	I give MSNJ permission to reach out to the appropriate government agency regarding this issue.
☐	I certify that the practice has attempted to resolve this issue with the payer.
☐	I give MSNJ permission to utilize a same specialty reviewer to evaluate my coding and documentation.

Email this form to 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.

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