Third Party Payer Issue Reporting Form

If you have been denied reimbursement by any third party payer (health plan or insurance carrier) and have not been able to resolve the problem, please complete this form and send it to POA so that the Eye Care Benefits Committee can gather data that may allow it to assist in resolving the issue.

Date: ____________________________ Doctor's Phone: ____

Doctor's Name ____

Doctor's Address ____

Doctor's E-mail Address ____

Name of Insurance Carrier or Health Plan ____

Plan Name or Type ____________________________ Employer Name ______________________________

Is this an ERISA plan (self funded?) ❑ YES ❑ NO

Provider representative contact name ____________________________ Phone # ______________________

Are you currently a credentialed provider for this plan? ❑ YES ❑ NO

Have you applied to become a provider and were turned down? ❑ YES ❑ NO

If turned down, what was the reason given to you? ____

____

Describe the problem(s) you have encountered ____

____

____

____

Have you tried to resolve the problem yourself? ❑ YES ❑ NO

If "YES," describe what you have done and what you have been told, including dates and names of contacts ____

____

____

____

____

Please forward this form and any hard copies of HCFA, EOBs or referral denials and/or other pertinent information to: Attn: Executive Director, POA, 218 North Street, Harrisburg, PA 17101; or fax (717) 233-6833; or e-mail **charlie@poaeyes.org**.