		-		NEW	JERS	EY P	IP PR	RE-SERVIC	E APF	PEAL	FORM	
TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED								DATE APPEAL SUBMITTED			2. RECEIPT DATE OF ADVERSE DECISION	
CLAIM INFORMATION												
3. INSURANCE COMPANY								4. CLAIM #				5. DATE OF LOSS
						F	PATIEN		ON			
6. LAST NAME								7. FIRST NAME			8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)								11. CITY			12. STATE	13. ZIP
						PROVI	DER/FA			N		
14. LAST NAME								15. FIRST NAME			16. FACILITY-OFFICE NAME	
17. SPECIALTY 18.								TAX ID #			19. NPI #	
20. ADDRESS (No. Street)								21. CITY			22. STATE	23. ZIP
24. TELEPHONE # (Include Area Code) 25. FAX # (Include Area Code) 26. EMAIL ADDRESS												
	7. PROVIDER AVAILABILITY DAYS OF WEEK: MONDAY TUESDAY WEDNESDAY TH						RSDAY				ILABILITY TIME OF I OM	DAY: TO
						D		ENTS INCLUD	ED			
29. CHEC	K THOSE	APPLICA	BLE BELOV	V (Include	Proof of R	eceipt if Ar	oplicable)				_	
*ORIGINAL APTP FORM *APTP DECISION/RESPONSE DOCUMENT *APPEAL RATIONALE NARRATIVE												
I INDEPENDENT MEDICAL EXAM REPORT I DIAGNOSTIC REPORT(S) I PEER REVIEW REPORT												
								CE APPEAL IS				
30. DATE(S) OF REQUEST FROM TO						HCPCS, NDC	C 32. RESPONSE NOT 33. A RECEIVED WITHIN 3 BUSINESS DAYS			DMINISTRATIVE DISPUTE	34. MEDICAL NECESSITY DISPUTE	
MM	DD	YY	MM	DD	YY			YES INDICATE	WITH X	YES I	NDICATE WITH X	YES INDICATE WITH X
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	<u>i </u>	<u>i </u>		<u> </u>	<u> </u>							
* Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only												
FRAUD PREVENTION-NEW JERSEY WARNING												
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.												
							PROV	IDER STATEMENT				

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

35. SIGNATURE OF PROVIDER Page 1 of 1