Out-of-Network Provider Negotiation Request Form

RESET

NJ physicians, hospitals, or other health care providers that **DO NOT PARTICIPATE** with Horizon BCBSNJ may complete this form to initiate negotiation for the reimbursement of claims for services provided to Horizon BCBSNJ members in compliance with the NJ Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (P.L.2018, c.32).

Mail completed forms to: **Horizon BCBSNJ**
PO Box 106
Newark NJ 07101

Or email to: OONSurpriseBill@horizonblue.com

- Please complete this form electronically (*rather than by hand*) to help expedite handling.
- Please submit a separate form for each negotiation request.
- Please do not submit new claims with this form.
- Please do not use this form to submit appeals or inquiries.

Subscriber/Patient & Claim Information

Subscriber's Name _____

Horizon BCBSNJ ID # _____
Include Prefix

Group # _____ Is this a Self-Insured[1] Group? ☐ Yes ☐ No ☐ Unknown

[1] *The back of a self-insured member ID card will include the following statement:*
"Horizon BCBSNJ provides administrative services only and does not assume any financial risk for claims."

If you selected "Yes," above, has this Self-Insured Group "opted-in" to P.L.2018, c.32? ☐ Yes ☐ No ☐ Unknown

Patient's Name _____

Patient's Date of Birth _____ Patient Account # _____
MM/DD/YYYY

Date of Service/Admission _____ Last Date of Service/Discharge _____
MM/DD/YYYY MM/DD/YYYY

Horizon BCBSNJ Claim # _____ Billed Charges _____

Procedure Code(s) ☐ I wish to negotiate ONLY the following codes(s). _____
☐ I wish to negotiate ALL submitted procedure code(s).

EOP Denial Reason/Message Codes _____
List all Denial Reason/Message Codes within the last column of your Explanation of Payment (e.g., G807, Z084a, Z464, etc.).

Nonparticipating Provider Information

☐ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, etc.) ☐ Ancillary Facility (SNF, etc.)

Provider Name _____

NPI # _____ Tax ID# _____

Address _____
Please include street address, city, state and ZIP code.

Contact Name: _____ Contact Email _____

Contact Phone _____ Contact Fax _____

Request Submission Date: _____
MM/DD/YYYY

Comments