ASNC Payer Policy Feedback Form

****Please complete and E-mail to ghearn@asnc.org, or Fax to (301) 215-7113.****

Please Provide the Following Information (*=Mandatory):

Physician Name:*_____
ASNC Member Number:*_____
Practice Name:*_____
E-mail Address:* _____
Office Phone Number: _____
Contact Person (if different from above): _____
Name of Health Plan you're having difficulty with: _____

Type of Plan/Carrier:

___ Managed Care Plan (Commercial)
___ Medicare Managed Care Plan
___ IPA
___ PPO
___ Commercial Insurance
___ Medicare
___ Medicaid
___ CHAMPUS
___ Worker's Compensation
___ Other (Please Specify: _____)

Type of Modality:

___ Cardiac CT
___ Cardiac MRI
___ Nuclear Imaging
___ PET

Type of Problem:

___ Delay in Payment
___ Denial of Claim
___ Pre/Post Payment Review
___ Denial of Preauthorization
___ Medical Necessity Review
___ Denial of Referral
___ Utilization Review
___ Other (Please Specify: _____)

Please provide a brief description of the problem you are experiencing with the payer:

_____
_____
_____
_____

Related CPT Codes: _____

Is this a…:
___ First Time Problem?
___ Recurring Problem?
___ Time Sensitive?

Have you contacted the payer directly?: ___Yes ___No

If yes, what actions did they take or what additional information were they able to provide?

_____
_____
_____

Please specify how we can be of any further assistance:

_____
_____
_____
_____
_____
_____
_____

The best way to reach me is by:
___ Phone
___ E-mail
___ Other (Please Specify: _____)

You may contact the ASNC Health Policy Department directly at: 301-215-7575 (ext. 207).