

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
MEDI-CAL PROVIDER MANUAL  
CLAIMS DEPARTMENT**

**VIII.B. Second Level Provider Claims Appeal – Partnership Medi-Cal Claims Appeal (Medi-Cal Appeal Form) – End Dated 12/31/23**

The Partnership Medi-Cal Claims Appeal process offers providers dissatisfied with the processing or payment of a claim, resubmission of a claim, or a claim inquiry, a method for resolving their dissatisfaction.

An Appeal may be submitted using the Medi-Cal Appeal Form (90-1). All Appeals must be signed. Each appeal may only include claims for one Partnership member. Do not submit an appeal if the claim is still in a pending status.

Supporting Documentation:

Necessary documentation should be submitted with each appeal to allow for a thorough review of the appeal. It is very important that all supporting documentation be legible. Include applicable attachments such as:

- \* Claim copy, corrected if necessary
- \* Copy of Partnership Remittance Advice (RA) Report
- \* Copy of POE printouts or Medi-Cal ID cards
- \* Copy of Medicare EOMB
- \* Copy of Other Coverage EOBs/RAs or denials
- \* Copy of all CIFs, Claims Inquiry letters, CIF Response Letters, or other dated correspondence to and from Partnership to document timely follow-up
- \* Copy of TAR or RAF
- \* Copy of manufacturer's invoice or catalog page
- \* Copy of the PCP prescription
- \* Copy of report for "By Report" procedures
- \* Copy of completed Sterilization Consent Form

Appeal submission timelines:

CIF denials for timeliness cannot be appealed.

A provider may submit a "Claim Appeal" within 90 days of the CIF denial. Failure to submit an appeal within the 90-day time period will result in the appeal being denied. A claim which is submitted on appeal has already been reviewed and denied by Partnership's Claims Department two separate times once on the original claim submission and once as the result of a CIF submission and/or a re-CIF.

Partnership will acknowledge an Appeal within 15 working days of receipt of the appeal and will respond with an Appeal Response Letter indicating the outcome of the appeal review within 45 working days. If the appealed claim is approved for adjustment, it will appear on a future RA. The claim will continue to be subject to claim processing criteria.

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Verification of Timely Submission:

The only acceptable documentation to verify timely submission of a claim is a copy of the Partnership RA, Claims Inquiry Acknowledgement (CIF), Claims Inquiry Response Letter, or any dated correspondence from Partnership containing a CCN with a Julian date falling within the twelve-month billing limit for the claim submission. A copy of the CIF alone without the accompanying Claims Inquiry Acknowledgement/Response Letter does not prove timely follow-up when filing an appeal and may cause the appeal to be denied.

Submit all Appeals to:

**Partnership HealthPlan of California  
Attn: Claims Department/Appeals  
P.O. Box 1368  
Suisun City, CA 94585-1368**

Instructions on completing the Appeal Form:

Each numbered item below refers to an area on the Medi-Cal Appeal Form shown on the previous page.

Item    Description

1.    *Appeal Reference Number.* For Partnership use only.
2.    *Document Number.* The pre-imprinted number identifying the Appeal Form.
3.    *Provider Name/Address.* Enter the following information: Provider Name, Street Address, City, State, and ZIP code.
4.    *Provider Number (Required Field).* Enter your provider number/National Provider Identifier (NPI). Without the correct provider number, appeal acknowledgement may be delayed.
5.    *Claim Type.* Enter an "X" in the box indicating the claim type. Only one box may be checked.
6.    *Statement of Appeal.* For information purposes only.
7.    *Patient's Name.* Enter up to the first 10 letters of the patient's last name.
8.    *Patient's Medi-Cal ID number/CIN (Required Field).* Enter the recipient ID number that appears on the RA showing adjudication of that claim.
9.    *Delete.* Enter an "X" to delete the corresponding line.

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10. *Claim Control Number* (Required Field if Appealing a Previously Adjudicated Claim). Enter the 12-digit number assigned by Partnership to the claim in question. (This number is the Control number found on the Partnership RA for the claim, plus the 4-digit number preceding each claim line).
11. *Date of Service*. In six-digit format (MMDDYY) enter the date the service was rendered. For block billed claims, you must enter the "from" date of service.
12. *EOB/RA Code*. When appealing a claim, enter the Partnership Adj Rsn/Remark for the claim line (e.g., 45, N14, 96, 4).
13. *Reason for Appeal*. Indicate your reason for filing an appeal. Be as specific as possible. In order for the examiners to properly research the complaint, all supporting documentation must be included.
14. *Common Appeal Reasons*. Check one of these boxes if applicable. Include a copy of the claim and supporting documentation (e.g., POE, TAR, EOMB). This box is for your convenience only. Leave Box 13 blank if this box is used.
15. *Signature*. This provider or an authorized representative must sign the Appeal Form.

A sample of the Medi-Cal Appeal form can be found on page 4 of this section.

For further information on how to complete a Medi-Cal Appeal form, please refer to the State of California Medi-Cal Provider Manual at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).