



Price-Negotiation Request Form

Fax: (906) 225-7690

Provider/Facility Name: _____

Provider/Facility Phone Number: () _____ Fax Number: () _____

Contact Name: _____

Member Name: _____ Recipient ID Number: _____

Procedure Code:	Diagnosis Code:	Service/Product Description:	Billed Charge:	Date of Service:
_____	_____	_____	_____	_____

- Attach copy of medical records and/or documentation to support billing of miscellaneous/penny-fee code.
- This form is only applicable for facility and/or physician offices requesting reimbursement for a miscellaneous service or drug. This form is not for DME/Medical Supply items – please refer to the *DME/Medical Supply Request Form*.
- This form will only be accepted up to 90 days after a claim denial. All requests made after that time will not be processed.

Additional comments: _____

** For UPHP Office Use Only **

Claims Department:

- Price negotiation approved. (*See below.*)
- Separate reimbursement for service not supported. (*See attached letter.*)
- Additional information / discussion needed. (*Contact provider.*)

Negotiated Price: _____

Time Frame (if applicable): _____

Limitation (if applicable): _____

Notes: _____

UPHP Reimbursement/Quality Control Analyst: _____ **Date:** _____

Intake Department: _____ **Date Received:** _____

Confirmation Number: _____ **Date Covered:** _____

Provider Notified: _____ **Fax:** _____ **Phone:** _____

Intake Representative: _____ **Date:** _____

**Please note – All covered benefits must meet MUPC & MSA guidelines.
Price negotiations are not authorizations and do not guarantee payment.**