



# Price Negotiation Request Form

Fax (906) 226-4284

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 a manually priced code.
- This form is only applicable for facility and/or physician offices requesting reimbursement for a manually priced service or drug. This form is not for DME item- 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:**

- Separate reimbursement for service not supported (*See attached letter*)
- Additional information / discussion needed (*Contact provider*)
- Request denied (*See notes section*)

**Negotiated Price:**

Time Frame (if applicable): \_\_\_\_\_

Limitation (if applicable): \_\_\_\_\_

Notes: \_\_\_\_\_

UPHP Reimbursement/Quality Control Analyst: \_\_\_\_\_ Date: \_\_\_\_\_

Please note – All covered benefits must meet MSA guidelines.  
 Approved requests will not be faxed back. Claims on file will be reprocessed at time of approval.  
Price Negotiations are not authorizations and do not guarantee payment.