Lab Toxicology Clinical Documentation

Attn: Provider Appeals
Fax Number: (567) 585 – 9500
Standard Mail: P.O. Box 497 Toledo, OH 43697-0497
Contracted providers are subject to Appeal Timely Filing contract language. Non-Contracted Providers are subject to UCM Default of (60) sixty calendar days in accordance with 29 CFR 2560.503-1

*IF SUBMITTING A CLAIM ADJUSTMENT/CODING REVIEW REQUEST PLEASE

Provider Name		NPI Number	
Medicaid ID Number		Phone Number	
Contact Name		Fax Number	
Date of Request		Place of Service	
Member Name		Member Date of Birth	
Member ID Number		Claim Number (1 claim per form)	
Date of Service		Authorization Reference #	
Billed Amount		Denied Explain Code	

URINE DRUG SCREEN CLINICAL APPEAL

Urine Drug Screen (890)	
Please Provide and Attach Evidence for the Following:	
1. The laboratory is enrolled with Ohio Medicaid as an independent laboratory. *(Medicaid ID #, etc.)*	2. Accreditation by the College of American Pathologists. *(Certification copy, accreditation #, etc.)*
3. That each specific CPT code submitted and tests performed were ordered by an appropriate provider (each code/service must be ordered).	4. Confirmation from the referring health care provider that each of the ordered toxicology results covered by this appeal were provided within two (2) business days of receipt of the test specimen.
5. Approved by the New York Clinical Laboratory Evaluation Program. *(Letter of approval, certification copy, etc.)*	6. Medical necessity from the applicable medical record for each CPT code submitted and tests performed.
Enter Rationale for Appeal Here	

I, the referring provider, attest that the specific test(s) involved in the current appeal process were ordered and, to the best of my knowledge, medically necessary.

X_____

I, the responsible party associated with the laboratory performing the test(s), attest to the accuracy of the information contained in this appeal.

X_____