NO-FAULT UTILIZATION REVIEW PROVIDER APPEAL REQUEST

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Utilization Review Section
DIFS-URAppeals@michigan.gov
Fax: 517-763-0305

Today's Date:	**Date of Insurer Determination:**
Note: A provider's appeal of a utilization review determination must be filed within 90 days of the date of the insurer's determination.	

I. PROVIDER AND CLAIM INFORMATION

Provider (name of physician, hospital, clinic, or other person/entity):	Provider Contact (name of person completing this form):
National Provider Identifier (NPI):	Phone Number:
Provider Address:	Fax Number:
	Email Address:
Claim Number(s):	Date of Accident:

II. CONTACT INFORMATION FOR THE INSURER/ASSOCIATION AND INJURED PERSON

Please provide the following information regarding the Insurer/Association and injured person:

Insurer/Association Name:	Injured Person Name:
Insurer/Association Address, City, State, ZIP:	Injured Person Address, City, State, ZIP:

III. INFORMATION ON APPEAL ISSUES

Please include the following information for each issue being appealed.

*Indicates required document. This form and all supporting documents must be sent securely. Further, failure to include required documents or otherwise include other documentation that is relevant to the appeal may result in a delayed response to the request for an appeal or the request being rejected, in full or in part, until complete documentation is provided within the time period remaining to file the appeal.

Please check which documents are included with this request.

☐ Detailed statement of reason(s) for the request for review (please attach)*.
☐ As applicable, a copy of the notice of determination under R 500.64(1) and/or denial of provider's bill under R 500.64(3) (please attach)*.
☐ As applicable, all documents related to requests for explanation exchanged between provider and insurer prior to this appeal request, pursuant to R 500.63 (please attach).
☐ Pertinent clinical information (please attach).
☐ Other supporting documents (please attach).

IV. PROVIDER CERTIFICATION AND ACKNOWLEDGEMENTS

PLEASE DO NOT LOCK THE SIGNATURE BOX; DOING SO WILL RESULT IN THE REJECTION OF YOUR APPEAL.

By signing this form, I understand and acknowledge that I will respond to the Department's inquiries regarding this appeal, and I certify that the information included on this form is correct and complete to the best of my knowledge and belief. I also understand and acknowledge that submitting false or misleading information is cause for denial of the appeal and may subject me and/or the provider to penalties as provided by law.

Authorized Signature:	Date:
Printed Name / Title:	Email Address: