REQUEST FOR RECONSIDERATION OF INPATIENT UM DETERMINATION (RRIU)
Post Discharge Review for Inpatient Services

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and NARRATIVE. Use additional pages if needed.
- Provide additional information to support the description of the dispute.
- Do not include a copy of a claim that was previously processed.
- Mail or Fax the completed form to: **Partnership HealthPlan of California**
  Attn: Utilization Management Department
  4665 Business Center Drive
  Fairfield, CA 94534
  Fax: (707) 863-4118

Has A Claim Been Submitted? ☐ **Y** ☐ **N** **If Yes, please submit a Provider Claims Dispute Resolution Request (Link)**
If No, please complete this form

***DISPUTE TYPE:**

☐ **RRIU to Reconsider for Medical Necessity.** Please check this box if you received a Notice of Action letter from our Utilization Management (UM) Department and you would like to appeal the medical necessity of the Level of Care authorization.

☐ Other _____

MEMBER INFORMATION:

***Member Name:**		***Date of Birth:**
***CIN/Mem ID Number:**	**Patient Account Number:**	***TAR Number:**
***Primary Reason for Admission:**		
Date ED Visit Began (If Admitted from ED)**:**	**Observation Dates/Times** (If applicable):	***Date of Member Admission:**
Date of Primary Surgery (if applicable)**:**	***Date of Discharge:**	***Patient Disposition Upon Discharge:**

PROVIDER INFORMATION:

***PROVIDER NPI:**	***PROVIDER TAX ID:**
***PROVIDER NAME:**	
***PROVIDER ADDRESS:**	
***PROVIDER TELEPHONE:**	***PROVIDER FAX:**

SUBMISSION INFORMATION:

***NAME OF PERSON SIGNING THIS RRIU SUBMISSION:**	***TITLE**
***TELEPHONE:**	***FAX:**
***NAME OF ASSISTANT HELPING PREPARE THIS RRIU SUBMISSION:**	***TITLE**
***TELEPHONE:**	***FAX:**

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INSTRUCTIONS:
- Attach any supporting clinical documentation.
- Please only send clinical records that are pertinent for the DOS you are contesting.
- Provide a clear explanation as to why the denial decision should be overturned in the space provided below.

***DESCRIPTION OF DISPUTE**:
- List days on which Partnership denied inpatient status for not meeting criteria for inpatient admission (Note: The date of discharge does not count as a billable/paid date.)
- Of these days, which dates does hospital want to have re-evaluated?

***NARRATIVE:**
- Summarize the reasons given by Partnership for lack of meeting criteria for inpatient coverage
- Please give a narrative of the description of circumstances that the reviewing Physician feels justify acute inpatient level of care, for each day they wish to contest.

***ATTACHMENTS REQUIRED:**

Please attach, for this hospitalization:
- The Admission and Physical note
- The Discharge summary note
- The hospital progress notes (including notes from consultants and primary rounding hospitalist) and any other supporting evidence for the contested days of care