FOR OFFICE USE ONLY:	
Patient Name:	
MCO:	DOS:
Hospital:	Decision:

Maryland
DEPARTMENT OF HEALTH

MCO/BHASO DISPUTE RESOLUTION COMMITTEE REVIEW FORM

INSTRUCTIONS:

The MCO/BHASO (Behavioral Health Administrative Services Organization) Dispute Resolution Committee reviews cases deemed complete. The submission is complete if the submission includes the following documents:

(1) MCO Remittance Report evidencing the completion of the appeal for the patient's MCO;
(2) BHASO Remittance Report evidencing the completion of the first level of appeal;
(3) Patient's UB04 Form;
(4) Patient's Medical Record from date(s) in question; and
(5) MCO/BHASO Dispute Resolution Review Form filled out sections:

- **a.** Hospital Information
- **b.** Patient Claim Information
- **c.** Remittance information
- **d.** MCO Remittance Information

Send complete submissions to:

Maryland Department of Health
ATTN: Maryland MCO/BHASO Dispute Resolution Committee
201 W Preston St
Room 523
Baltimore, MD 21201

Failure to include documents or properly fill out the form may result in either (1) significant delay in the Committee's review of the case or (2) return of the incomplete case file.

If the submission is complete, the Committee will return a decision within 45 days. Please refrain from contacting the Committee to check on the status of a decision within those 45 days.

LIMITATIONS:

The Committee's scope of authority to make determinations is limited to disputes concerning whether treatment is medical or behavioral health. Concerns regarding receipt of payment should not be sent to the Committee since ensuring payment is outside the scope of the Committee.

The Committee does not accept and will not review cases:

(1) Where the date of service exceeds one year's time from the date stamp of envelope or email,
(2) If the third party payor is a commercial payor,
(3) In the appeal process of either BHASO or the patient's MCO, or
(4) Where the dispute concerns medical necessity, other procedural, or administrative requirements necessary for payment.

*****The information required for a complete MCO/BHASO Dispute Resolution Form has PHI, therefore, submission should be faxed, mailed or sent via a password protected secure email*****

FOR OFFICE USE ONLY:
Patient Name:
MCO: DOS:
Hospital: Decision:

Hospital Information

Referring Contact: _____ Email: _____

Hospital Name: _____ Phone: _____

Mailing Address: _____

Patient Claim Information

Patient Name: _____ Patient DOB: _____

Patient MA#: _____ Patient MCO Name: _____

Patient SS#: (if no MA#) _____ Date(s) of Service: _____

Level of Service: (ex: ER, inpatient, etc.) _____ Primary Discharge Diagnosis: ***(Attach UB04)*** _____

Behavioral Health Administrative Service Organization Information

Date bill submitted to BHASO: _____ Remittance advice date: _____

Reason for denial: _____

_____

Report date of appeal/decision: _____
(Attach all documentation)

Managed Care Organization Information

Date bill submitted to MCO: _____ Remittance advice date: _____

Reason for denial: _____

_____

Report date of appeal/decision: _____
(Attach all documentation)

*****The information required for a complete MCO/BHASO Dispute Resolution Form has PHI, therefore, submission should be faxed, mailed or sent via a password protected secure email*****

Rev. 5/2021