

**MEDICAL NECESSITY CLAIM DENIAL QUESTIONNAIRE**

*Please answer all of the following questions for each claim denied based on medical necessity. This Questionnaire may be most appropriately filled out by your office billing manager. Please complete one form for each claim denied.*

WHEN COMPLETED, PLEASE REMIT THIS FORM TO:

SHERNOFF BIDART ECHEVERRIA, LLP  
ATTN: MEDICAL NECESSITY  
600 SOUTH INDIAN HILL BLVD.  
CLAREMONT, CA 91711  
Tel: (800) 458-3386 or (909) 621-4935  
Fax: (909) 625-6915

*(If you have any questions, or if you would rather fill out this information over the phone, please contact Paul Ruggero at (909) 621-4935.)*

This form is also available at [www.shernoff.com](http://www.shernoff.com)

**1. DOCTOR'S CONTACT INFORMATION**

DOCTOR'S NAME \_\_\_\_\_

CURRENT ADDRESS \_\_\_\_\_  
Number Street Apt. No.  
\_\_\_\_\_  
City State Zip

TELEPHONE Home: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_  
Other: (\_\_\_\_\_) \_\_\_\_\_

**AREAS OF SPECIALTY**

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**2. FACILITY INFORMATION** *(If the facility in which the service was provided has also submitted a claim which has been denied, please fill out this section. If not, go to question #3.)*

**NAME OF FACILITY (CLINIC, HOSPITAL, ETC.)** \_\_\_\_\_

**FACILITY ADDRESS** \_\_\_\_\_  
**Number**                      **Street**    **Suite No.**  
\_\_\_\_\_  
**City**    **State**    **Zip**

**FACILITY TELEPHONE** (\_\_\_\_\_) \_\_\_\_\_

**FACILITY TAX ID NUMBER** \_\_\_\_\_

**3. PATIENT'S CONTACT INFORMATION** *(Please provide information regarding the patient who's claim for treatment has been denied.)*

**PATIENT'S NAME** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_

**CURRENT ADDRESS** \_\_\_\_\_  
**Number**                      **Street**    **Apt. No.**  
\_\_\_\_\_  
**City**    **State**    **Zip**

**TELEPHONE**    Home: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_

Other: (\_\_\_\_\_) \_\_\_\_\_



**5. NATURE OF CLAIM**

**A. RETROSPECTIVE** (*Services rendered before medical necessity denial.*)

YES \_\_\_\_\_

NO \_\_\_\_\_

**B. PROSPECTIVE** (*Denial of prior authorization.*)

YES \_\_\_\_\_

NO \_\_\_\_\_

**6. NATURE OF TREATMENT DENIED**

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Health problem	Dates of treatment
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Health problem	Dates of treatment
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Health problem	Dates of treatment
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**DATE OF DENIAL** \_\_\_\_\_

*(If there have been multiple denials of the same claim, please provide last date of denial.)*

**REASON SERVICES WERE/ARE MEDICALLY NECESSARY** \_\_\_\_\_

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**SPECIFIC REASON GIVEN FOR DENIAL BY INSURER** \_\_\_\_\_

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**7. AMOUNT OF CLAIM**

**AMOUNT BILLED FOR SERVICES DENIED**

a. Doctor \_\_\_\_\_

b. Facility \_\_\_\_\_

c. Other \_\_\_\_\_

**TOTAL** \_\_\_\_\_

**WAS THE PATIENT BILLED DIRECTLY FOR ANY OF THESE SERVICES?**

**YES** \_\_\_\_\_ **AMOUNT** \_\_\_\_\_

**NO** \_\_\_\_\_

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