



## OASAS Insurance Survey

**Instructions:** Please complete this form for **each insurance denial** which you or your organization encountered. Complete and mail one form for each incident as they occur.

### A. CONTACT INFORMATION:

Name of Organization or Agency Code	Telephone Number
Name of Individual completing this form	
Program Generated Client Id # (Optional)	

### B. INSURANCE INFORMATION:

Name of Insurance Carrier			
Name of Behavioral Health/Managed Care Company			
<b>Provider Relationship with Insurance Company</b>	<input type="checkbox"/> Contracted Network Provider	<input type="checkbox"/> Non –Contracted Network Provider	
<b>Type of Health Plan</b>			
<input type="checkbox"/> HMO	<input type="checkbox"/> Preferred Provider Organization (PPO)	<input type="checkbox"/> Point of Service Plan (HMO-POS)	<input type="checkbox"/> Indemnity
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicaid HMO	<input type="checkbox"/> No Insurance	<input type="checkbox"/> Don't know
<input type="checkbox"/> Family Health Plus	<input type="checkbox"/> Other	<input type="checkbox"/> Commercial	

### C. CLINICAL DENIALS – Complete Section Below

<b>Client Diagnosis</b>	
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Medical and/or Psychiatric
<b>C.1 PRECERT - EAP or Treatment Provider's Recommendation:</b>	<b>C.2 Insurer's or Managed Care Organization's Recommended / Proposed Level of Care</b>
<input type="checkbox"/> Inpatient Detoxification: Indicate Program Type:	<input type="checkbox"/> Detoxification
<input type="checkbox"/> Outpatient Detoxification	<input type="checkbox"/> Substance Abuse Program in Psychiatric Hospital
<input type="checkbox"/> Substance Abuse Program in Psychiatric Hospital	<input type="checkbox"/> Hospital-based Rehabilitation Program
<input type="checkbox"/> Hospital-based Rehabilitation Program	<input type="checkbox"/> Free-standing Rehabilitation
<input type="checkbox"/> Free-standing Rehabilitation	<input type="checkbox"/> Intensive Outpatient Program
<input type="checkbox"/> Intensive Outpatient Program	<input type="checkbox"/> Traditional Outpatient Provider
<input type="checkbox"/> Traditional Outpatient Provider	<input type="checkbox"/> Residential Therapeutic Community
<input type="checkbox"/> Maintenance Therapy (MTP / Suboxone)	<input type="checkbox"/> Individual Therapist
<input type="checkbox"/> Other	<input type="checkbox"/> Community Supports (self help such as AA, NA, Etc.)
	<input type="checkbox"/> Maintenance Therapy (MTP / Suboxone)
	<input type="checkbox"/> Other
<input type="checkbox"/> Insurance Company standards more stringent than OASAS requirements	
<b>C.3 Treatment Decisions</b>	
<input type="checkbox"/> Length of Stay	<input type="checkbox"/> Medical Necessity Questions
	<input type="checkbox"/> Level of Care

### D. ADMINISTRATIVE DENIALS – Complete Section Below: Check all that apply

<b>D.1 Claim Submission Process</b>			
<input type="checkbox"/> Clean claims	<input type="checkbox"/> Computer system problems	<input type="checkbox"/> Revenue Code not definitive	<input type="checkbox"/> Multiple authorizations required
<b>D.2 Network Access / Practitioner Limitations</b>			
<input type="checkbox"/> CASAC denials	<input type="checkbox"/> Other Professionals denied due to level of licensing / credentialing requirement		
Is there an outside entity credentialing facility staff? <input type="checkbox"/> Yes <input type="checkbox"/> No What Company? (if yes)			
<b>D.3 Benefit Clarification of Covered Services</b>			
<input type="checkbox"/> (Initial Service Approval Revoked)			
Revocation indicated either: <input type="checkbox"/> Not a covered service or <input type="checkbox"/> not covered at that level of care or length of stay.			



**E. COMPLAINT INFORMATION:**

<b>Complaint</b>		Date of Insurance Denial	
Complaint made by	<input type="checkbox"/> Mail	<input type="checkbox"/> Telephone	<input type="checkbox"/> In person
Person contacted	Title		
Did you file a formal internal appeal or grievance with the health plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What was the response to the above complaint or appeal?			
Has the matter been submitted to another agency :		<input type="checkbox"/> external appeal to State Insurance Department	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> complaint to the Department of Health Office of Managed care		
		<input type="checkbox"/> private attorney?	

**F. OUTCOME – Additional Comments (e.g. What Eventually Happened or Current Status of the Appeal)**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Mail completed form to: NYS OASAS  
Att: Counsel's Office  
1450 Western Avenue  
Albany, NY 12203