NEW IDEAS Claim Check List

Request for NEW IDEAS Billing Assistance for Claim Denial

Ensure all the following items have been completed prior to submitting a request for assistance.

☐ Review sample claim forms for the site of service that applies to ***your*** claim. Verify all elements on the claim that are required or recommended are present on the submitted claim. Sample claims are located at the following **URL:** **https://www.ideas-study.org/During-Study/Medicare-Reimbursement**

☐ Check the New IDEAS Billing FAQ located at the following **URL:** https://www.ideas-study.org/About-Us/FAQ

☐ Locate your local Medicare Administrative Contractor (MAC), Local Coverage Policy or Article and Bulletins for PET services. Maintain this in your billing department and check for periodic changes. ***Attach policy with request for assistance, if applicable.***

☐ If you are an Independent Diagnostic Testing Facility (IDTF), verify the CMS 855-B Application has been submitted adding both the procedure CPT and radiopharmaceutical HCPCS codes, if they are not already listed for your site. ***Maintain this approval of listed codes in your billing department.***

*The below should be completed by the person requesting billing assistance. This should be submitted by the person that has the most knowledge of the billing, preferably the biller but may be others involved with New IDEAS. This form should **not** be completed by an industry representative. Send completed form and attachments to the New IDEAS-Study for routing: NewIdeas@acr.org*

Check only one:
Provider type: ☐ MD Office ☐ IDTF ☐ Hospital Outpatient
Claim Information: ☐ Single ☐ Multiple **"Like"** Claim (complete attached sheet) number of claims: _____
Medicare type: ☐ Traditional Medicare ☐ Medicare Advantage (MA Plan)

Provider Name:		*Contact at Provider Site:*	
Provider Address:		*Contact Position/Title:*	
State Service Provided:		*Contact Phone:*	
MAC or MA Plan Name:		*Contact E-Mail*	
MAC or MA Plan Phone and/or E-mail:		*Date of Service (DOS) or Span of dates of issues:*	
Date Last Communicated with payer:		*Reason for Denial:*	
Description of the billing issue and other pertinent information:			

It is important that providers DO NOT send New IDEAS patient specific information. Please provide claim submission(s) and explanation of benefits (EOB), de-identifying any patient specific information, DO include the ICN and DOS.

Provider Request for NEW IDEAS Claim Processing Assistance (For use with multiple "LIKE" claims)

Number	MAC or MA Plan	ICN	DOS	Appeal Status
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

☐ **Check here if additional information is attached.**

This form and attachments may be sent to *NewIdeas@acr.org.*