685 Highway 202/206, Suite 301
P.O. Box 5919
Bridgewater, NJ 08807
(908) 243-1800
Toll free 1-800-987-2032
Fax 1-877-397-5868

INITIAL INFORMATION LETTER TO INSURED/CLAIMANT/PROVIDER/ATTORNEY

«Date

«PersonName_To»	RE:	«PersonName_Claimant»
«CompanyName_To»	Claim #:	«ClaimNumber»
«Address_To»	DOL:	«DateLoss»

«Dear»

Please read this information carefully and share it with your treating health care providers.

Under New Jersey's Automobile Insurance Cost Reduction Act, there are obligations which you must satisfy for coverage of medically necessary treatment, diagnostic testing, durable medical equipment and other services arising from injuries sustained in an automobile accident. During the course of your claim, you may be contacted by our PIP vendor, Prizm, LLC as it relates to obligations you have while receiving medical treatment for your injuries and any subsequent bills. Failure to abide by the following obligations may affect the authorization and/or reimbursement for medical treatment, diagnostic testing and durable medical equipment.

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed medically necessary and causally related to the motor vehicle accident. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the internet at the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm.

Prizm, LLC has been selected by Mercury Indemnity Company of America as its PIP Vendor to implement their plan as required by the Automobile Cost Reduction Act. Prizm will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, provide Case Management Services and administer the Internal Appeals Process.

If certain medically necessary services are performed without notifying Mercury Indemnity Company of America or Prizm, LLC, a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-certification. Such treatment (within the first 10 days) shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

The Plan Administrator of this plan is:

Prizm, LLC
1015 Briggs Road
Suite 100
Mt. Laurel, NJ 08054

Phone Number:	856-596-5600
Fax Number:	856-596-6300
Email Address	Documents@Prizmllc.com

Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification

Please complete the attached "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to Prizm by fax (856-596-6300), or mail (1015 Briggs Road, Ste. 100, Mt. Laurel, NJ 08054) or email to TreatmentRequests@Prizmllc.com. This form can be accessed on Prizm's web site at www.Prizmllc.com. Any questions regarding your treatment request can be directed to Prizm at 856-596-5600 during regular business hours of Monday through Friday 8:00 AM to 5:00 PM, EST (or 5:00 PM EDT, as applicable) except for Federal and/or State Declared Holidays and/or New Jersey declared "State of Emergencies" related to inclement weather where travel is prohibited.

Mercury Indemnity Company of America's Personal Injury Protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with NJ personal injury regulations. "Medically necessary" or "medical necessity" means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols consisting of evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals;
2. The Care Paths, as applicable;
3. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
4. Does not include unnecessary testing or treatment.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluoroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms
16. Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation.

Mandatory Pre-Certification

In accordance with N.J.A.C. 11:3-4.7, Mercury Indemnity Company of America's Decision Point Review and Pre-Certification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to pre-certify these services may result in penalties/co-payments even if services are deemed medically necessary. If the eligible injured person does not have an Identified Injury, you as the treating provider are required to obtain Pre-Certification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion Therapy
- Extended Care Rehabilitation Facilities

- All Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths
- All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with decision point review.
- All Outpatient psychological/psychiatric treatment/testing and/or services
- All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
- Home Health Care
- Acupuncture
- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $100.00
- Non-Emergency Dental Restorations
- Temporo-mandibular disorders; any oral facial syndrome
- Current Perception Testing
- Computerized Muscle Testing
- Nutritional Supplements
- All treatment and testing related to balance disorders
- Bone Scans
- Podiatry
- Any all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPCS code
- Prescription Drugs costing more than $50.00

Decision Point Review/Pre-Certification Process
On behalf of Mercury Indemnity Company of America, Prizm, LLC will review all treatment plan requests and medical documentation submitted. A decision will be rendered three business days after the receipt of a completed Attending Provider Treatment Plan form request with supporting medical documentation.

In the event that Mercury Indemnity Company of America or Prizm, LLC does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received. If additional information is requested, the decision will be rendered within three days of our receipt of the additional information. If a decision is not rendered three business days after receipt of an "Attending Provider Treatment Plan " form, you, as the treating health care provider, may render medically necessary treatment until a decision is rendered.

All treating providers are required to submit all requests on the "Attending Provider Treatment Plan" for Decision Point Review and Pre-Certification treatment requests. A copy of this form can be found on the NJDOBI web site http://www.state.nj.us/dobi/pipinfo/aicrapg.htm. or at Prizm's web site www.Prizmllc.com.

Failure to submit a completed Decision Point Review and Precertification treatment request, including but not limited to a completed "Attending Provider Treatment Plan" and legible clinically supported records will result in the submitting provider being notified, within three business days of the incomplete submission of what is needed to complete the precertification submission.

Providers who submit Decision Point Review/Precertification are those providers who physically and personally perform evaluations of the injured person's condition, state the specific treatment and set treatment goals. Mercury Indemnity Company of America (by its PIP vendor Prizm) will not accept Decision Point Review/Precertification requests from the following providers:

- Hospitals
- Radiologic Facilities
- Durable Medical Equipment Companies
- Ambulatory Surgery Centers
- Registered bio-analytical laboratories;
- Licensed health maintenance organizations
- Transportation Companies
- Suppliers of Prescription drugs/Pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request Prizm will respond to them three business days after the request informing them that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

A decision to the provider's request for treatment/testing/Durable Medical Equipment, prescriptions or other services will be communicated 3 business days after the treatment request is received by the Mercury Indemnity Company of America's PIP vendor, Prizm, LLC. This decision is communicated to the requesting provider by fax or mail during business hours. All decisions regarding requests for pre-certification will be transmitted to the provider identified on the Attending Physician Treatment Plan forwarded for consideration. If another business or entity faxes an Attending Physician Treatment Plan to Prizm, LLC, or requests notification of decision regarding requests for pre-certification, that business or entity will not receive same; notifications will strictly be sent to the provider identified on the Attending Physician Treatment Plan who requested the specified treatment, testing, ~~or~~ Durable Medical Equipment, prescriptions or other services.

Failure to request decision point review or pre-certification (including treatment of Identified Injuries after 10 days) where required or failure to provide clinically supported findings that support the treatment, test or durable medical equipment requested shall result in an additional copayment of 50% of the eligible charge for medically necessary diagnostic tests, treatments, durable medical goods, prescriptions or other services that were rendered between the time notification to the Mercury Indemnity Company of America or its PIP vendor, Prizm was required and when Prizm communicates the decision 3 business days after the receipt of the treatment request. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

In accordance with NJAC 11:3-4.7:

- Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.
- If Mercury Indemnity Company of America's PIP vendor, Prizm, fails to respond to the request three business days after the receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.
- The treating provider must be notified of the decision after the stated 3 business days by fax or mail (as defined by date of postmark).

As it relates to this Decision Point Review Plan, the following applies when "Days" are referenced:

- "Days" means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included.
- The last day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday, legal holiday nor New Jersey Declared State of Emergency.

Example: Response on Decision Point Review and Precertification requests must be communicated to the treating provider no later than three business days after the submitted request. A provider submits a proper request on Monday at 6:00 PM, which is 1 hour after the close of business hours at 5:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Example:
"Decisions on Pre-Service Appeals shall be communicated to the provider no later than 14 days after receipt of a completed pre-services appeal and any supporting documentation. The insurer receives the appeal by facsimile, transmission dated 3:00 P.M. on Tuesday, January 8. Day one of the 14 day period

is Wednesday, January 9. The 14th day would be Tuesday, January 22, however there is a State of Emergency Declared in New Jersey on Tuesday January 22nd due to inclement weather. The insurer's decision is due no later than Wednesday January 23rd, providing the State of Emergency has been lifted.

No Decision Point or Precertification requirements shall apply within 10 days of the injured party's event or to treatment administered in emergency care as stated in NJAC 11:3-4.7. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary. Any treatment that is administered after the above 10 day period (including Identified Injuries set forth in NJAC 11:3-4, et seq.), where PRIZM was not provided prospective notice, will be subject to retrospective review as well as the appropriate co-payment penalties.

Decisions That May Be Communicated to You:
Approved – A request for treatment/testing/Durable Medical Equipment, prescriptions or other services is approved by either the Nurse or a Physician Advisor (if forwarded to a Physician Reviewer) or as a result of an Independent Medical Examination.

Denied – A request for treatment/testing/Durable Medical Equipment, prescriptions or other services is denied either by a Physician Advisor or an Independent Medical Examiner.

Modified – A request for treatment/testing/Durable Medical Equipment, prescriptions or other services is modified either by a Physician Advisor or an Independent Medical Examiner.

Administrative Denial – Failure to submit "Attending Provider Treatment Plan" or an incomplete Decision Point Review and Pre-Certification treatment request, including but not limited to an incomplete or unsigned "Attending Provider Treatment Plan", and legible clinically supported record will result in the submitting provider being notified three business days after the incomplete submission of what is needed to complete the precertification submission. Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three business days after the submission.

Retrospective Date of Service – If the request for treatment/testing/Durable Medical Equipment, prescriptions or other services is for a Date of Service which has already occurred, a decision of Retrospective Date of Service will be rendered.

Pended to IME – If, based on the Physician Advisor's opinion, a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient location to the examinee is scheduled within 7 calendar days of the date of the request.

Restricted – Provider prohibited from submitting Decision Point Review/Precertification. Provider will be instructed that the submission must be made by the referring/treating provider.

Previously Requested – If the requested treatment/testing/Durable Medical Equipment has already been requested by the same provider (DOS and CPT codes) or an ancillary provider (related CPT codes to primary procedure i.e., anesthesia for surgery), a decision of previously requested will be entered and the decision of the previously requested service will be forwarded to the provider submitting the request.

Please note that the denial of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Voluntary Pre-Certification
We encourage you, as the treating health care provider, to participate in a voluntary pre-certification process by submitting a comprehensive treatment plan to Prizm for all services provided. Prizm will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills you submit consistent with the agreed plan will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient,

provider and Prizm to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

Independent Medical Examinations
Prizm or Mercury Indemnity Company of America may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request by the treating provider.

Prizm shall notify the injured person or designee if a physical examination is required to determine the medical necessity of further treatment, test, or durable medical equipment. If a physical or mental examination is required, the appointment will be scheduled within seven (7) calendar days of the date of the request for the treatment, test or durable medical equipment unless the injured person/designee agrees to extend the time period. It is noted that medically necessary treatment can continue while the examination is being scheduled.

Prizm, on behalf of Mercury Indemnity Company of America, shall notify by mail the injured person or his designee and shall notify by fax the requesting provider whether reimbursement for further treatment or test is authorized as promptly as possible, but no later than 3 business days after the examination.

The examination shall be scheduled with a provider of the same discipline and the most appropriate specialty related to the treating diagnoses as the treating provider and within a location reasonably convenient to the patient. The injured person, upon the request of Mercury Indemnity Company of America or Prizm, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.

If the injured party being examined does not speak English, they must notify Prizm who may be able to arrange an English Speaking Interpreter. The injured person can also provide their own Interpreter at their own cost.
Prizm will notify the injured party or designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at more than one appointment. If the injured party has more than one unexcused failure to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This is notice that all treatment, diagnostic testing, ~~or~~ durable medical equipment, prescriptions or other services required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence of failure to comply with the plan.

The following will constitute an unexcused failure:

1. Failure of the Injured Party to attend a scheduled IME without proper notice to Prizm.
2. Failure of the Injured Party to notify Prizm at least two (2) business days prior to the scheduled IME date, seeking to cancel or reschedule.
3. Any rescheduling of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from Mercury Indemnity Company of America or Prizm.
4. Failure to provide requested medical records, including radiology films, at the time of the IME.
5. If the injured party being examined does not speak English, failure to request or provide an English speaking Interpreter for the exam.
6. Failure to provide adequate proof of identification.
7. Failure to contact Prizm to arrange for transportation to the examination, if required.

Voluntary Network Services

Prizm has established a network of approved vendors for diagnostic imaging studies for all MRI's and CAT Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all

electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG H-Reflex and NCV studies by your treating provider). Failure to utilize the voluntary network providers will result in a co-payment penalty of 30%. This co-payment is in addition to any other co-payment stated in the insured's policy or Decision Point Review Plan. If you, the injured party, utilize one of the pre-approved networks, the 30% co-payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG H-Reflex and NCV studies, the 30% co-payment will not apply.

When one of the services listed below is authorized through Mercury Indemnity Company of America ***Decision Point Review/Pre-Certification*** process, detailed information about voluntary network providers will be made available to the claimant or requesting provider. Those individuals who choose not to utilize the networks will be assessed an additional co-payment not to exceed 30% of the eligible charge. That co-payment will be the responsibility of the insured or injured party.

Once an **MRI and/or CAT Scan Diagnostic** test that is subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact you, the injured party, and schedule the test at a time and place convenient to them.

Durable Medical Equipment with a cost or monthly rental over $100.00 is subject to Decision Point Review/Pre-Certification process and once the *Durable Medical Equipment* is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. The equipment will be shipped to you, the injured party, from the vendor, 24 hours after the request is received.

When you are in need of **Prescription Drugs** a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to you once the need for a prescription has been identified.

Once an **Electro-diagnostic Test** subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will then contact you, the injured party, and schedule the test at a time and place convenient to them.

Network Providers (unless advised to the contrary at the time of approval) are:

Diagnostic Radiology Network:
Atlantic Imaging Group: 1-888-340-5850 / www.aignetwork.com

Pharmacy & Ancillary / DME:
myMatrixx: 1-877-804-4900 / www.mymatrixx.com
Cypress Care 1-800-419-7191 / www.cypresscare.com

Penalty Notification

Failure to submit requests for Decision Point Review or Pre-certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co-payment is in addition to any co-payment stated in the insured's policy or this Plan.

The injured party is required to inform Mercury Indemnity Company of America about the injury and the claim, including the information from regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment. This information may be required to be provided as promptly as possible after the accident, and periodically thereafter. An additional co-payment penalty shall be applied for failure to supply the required information. Such penalty shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than 25% when received 30 or more days after the accident; or 50% when received 60 or more days after the accident. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

Assignment of Benefits

Assignment of Benefits – If the provider accepts assignment for payment of benefits please be aware that the provider is required to hold harmless the insured and the insurer for any reduction of benefits caused by the provider's failure to comply with the terms of Decision Point Review/Pre-Certification Plan.

Please note that any provider that has accepted an assignment of benefits or any insured must comply with and complete the Appeals Process as noted below prior to initiating arbitration or litigation. Completing the appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

Additional conditions of assignment:
Any assignment will not be valid and enforceable unless the health care provider consents to consolidate all actions currently pending involving the same injured party and/or accident.

Failure by the health care provider to fully comply with the conditions of assignment will render any attempted assignment void and unenforceable. Any assignee must fully comply with the Mercury Decision Point Review and Pre-Certification Plan; must provide complete and legible medical records or other pertinent information when requested by us, and must submit to statements or examinations under oath concerning the treatment provided to the patient as often as deemed reasonable and necessary.

Internal Appeal Process

In accordance with NJAC 11:3-4.7B, the Mercury Indemnity Company of America ("Mercury") Internal Appeals Process, administered by Prizm, LLC, is as follows:

This section applies to all appeals that are submitted on or after April 17, 2017.

The internal appeals process shall permit a provider of Medical Services who has been assigned benefits to appeal any adverse decision. An adverse decision is any determination by Mercury or Prizm, LLC with which the provider does not agree.

Internal appeals are divided into two types of appeals—**Pre-Service Appeals** and **Post-Service Appeals**. An appeal is a condition precedent to any request for alternative dispute resolution in accordance with N.J.A.C. 11:3-5. Only one-level appeal procedure is required for each issue to be appealed before making a request for alternative dispute resolution in accordance with N.J.A.C. 11:3-5.

An appeal must be in writing and submitted to Prizm, LLC on the Pre-Service Appeal Form or the Post-Service Appeal Form, as applicable, as established by the New Jersey Department of Banking and Insurance and posted on the Department's website. (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm)

An appeal which is incomplete, illegible, or fails to supply documentation and proofs in accordance with this INTERNAL APPEALS PROCESS, will be administratively denied. Any appeal administratively denied shall be deemed null and void and a failure to comply with the terms of the Mercury Decision Point Review and Pre-Certification Plan in the event that the provider of service benefits files for Alternative Dispute Resolution or files an action in the Superior Court of New Jersey prior to or without making the corrections as necessary. A Post-Service appeal which was not timely filed in accordance with this section and N.J.A.C. 11:3-7B shall be null and void and a failure to comply with the terms of the Mercury Decision Point Review and Pre-Certification Plan. A Pre-Service appeal which was not timely filed in accordance with this section and N.J.A.C. 11:3-7B, in the event that the provider of service benefits files for Alternative Dispute Resolution or files an action in the Superior Court of New Jersey, shall be deemed null and void.

A provider of service benefits who has failed to timely file a timely pre-service appeal may submit a new, properly filed Decision Point Review or Pre-certification request prior to performing services.

We may request additional information or documentation. The deadline for our appeal response will stop or freeze until we receive the additional information or documentation.

An assignment of benefits shall be deemed null and void as to any provider of Medical Services who fails to properly file an appeal under this section prior to the filing of Alternative Dispute Resolution or an action in the Superior Court of New Jersey.

In accordance with N.J.A.C. 11:3-7B (j), nothing herein shall be construed as to require reimbursement of services that are not medically necessary or to prevent the application of penalty copayments in accordance with N.J.S.A. 11:3-4.4 (e).

All appeals under this section must be submitted to Prizm, LLC by fax at 1-856-596-6300 or electronically at Documents@PrizmLLC.com.

Pre-Service Appeals
The health care provider may request Prizm, LLC to review any adverse decision with respect to requested treatment, diagnostic testing, other service or prescription for any medication or durable medical equipment that has not been provided. An adverse decision includes a denial or modification of benefits. Appeals as to denials or modifications of Decision Point Review or Precertification requests shall be made as pre-service appeals.

A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial, modification or adverse decision. The appeal must indicate the issue being appealed. An appeal rationale narrative is required to be included with the form. Attached to the request you must provide any new or additional information or documentation you wish to be considered and upon which you intend to rely upon, now or in the future.

A response to a complete and properly filed pre-service appeal shall be made no later than 14 days after receipt of a completed pre-service appeal and any supporting documentation. If it is determined that an Independent Medical Examination is necessary, this information will be communicated within 14 days after receipt.

A pre-service appeal may be submitted solely by a health care provider who physically and personally performs evaluations of the injured person's condition, states the treatment and sets treatment goals, and who is authorized under the Mercury Insurance Group Decision Point Review and Pre-Certification Plan to submit Decision Point Review/Pre-Certification requests.

Post-Service Appeals
A post service appeal is filed subsequent to the performance or issuance of services. A post service appeal shall be submitted at least 45 days prior to initiating alternative dispute resolution pursuant to N.J.A.C. 11:3-5.

As a condition precedent to filing a request for alternative dispute resolution, a provider of service benefits who has accepted an assignment and has received an adverse decision, subsequent to the performance or issuance of services as to what the insurer should reimburse the provider for that service, must submit an appeal as to all disputed issues. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service and/or durable medical equipment of the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider for that same service. An appeal rationale narrative is required to be included with the form.
Attached to the request, you must provide any information or documentation you wish to be considered and upon which you intend to rely upon, now or in the future, in support of the objection to any adverse decision. The appeal must clearly indicate what issue is being appealed.

Appeals regarding a dispute as to the usual, customary and reasonable reimbursement for services shall include documentation upon which the provider relies to establish its' usual, customary and reasonable

fees received from all payors. Appeals regarding any dispute as to any PPO agreement must provide all information and documentation which the health care provider intends to prove or rebut the application of the PPO agreement and/or the rates paid or payable under such agreement. Appeals regarding a dispute as to Health Care Primary coverage must also include all Explanation of Benefits forms received by the provider and/or patient from the Health Care Insurer.

Our decision will be issued no later than 30 days after receipt of a properly filed post-service appeal form and any supporting documentation.

Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

Payments/ Reimbursement
Mercury Indemnity Company of America will reimburse all eligible medically necessary services in accordance with the applicable New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When a provider bills CPT codes for medically necessary services that are not noted in a fee schedule, Mercury Indemnity Company of America will reimburse the service considering fees for similar services on the fee schedule or the most current version of FAIR Health Data Base, consistent with the date of service, 75th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee, whichever is less.

For Pharmacy bills which are not noted in a fee schedule, Mercury Indemnity Company of America will use the most current version of the Goldstandard with the geozip noted on the provider's address noted on the Explanation of Benefits.

Mercury Indemnity Company of America may have no obligation to reimburse for specific CPT/HCPCS codes even if they were approved (certified) in a Decision Point Review/Precertification. If the NCCI edits or New Jersey law prohibits reimbursement for the codes that were billed, such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of the Mercury Indemnity Company of America's obligation to only reimburse for medically necessary treatment. You may obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/

Dispute Resolution Process
As to disagreements arising from issues of Personal Injury Protection coverage, not subject to or resolved by the Internal Appeals Process, the DRP is the sole and exclusive method or remedy for resolving disputes.

If the treating provider is not satisfied with the results of Prizm's Internal Appeals Process, the treating provider may file for Dispute Resolution, governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on the Forthright website, http://www.nj-no-fault.com. Mercury Indemnity Company of America retains the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unless emergent relief is sought, failure to utilize the Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

Sincerely,

Mercury Indemnity Company of America

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY | CLAIM #: | DATE SUBMITTED: Month / Day / Year

PATIENT INFORMATION

1. PATIENT'S NAME — Last / First / Initial
2. PATIENT'S ADDRESS (No. Street)
3. CITY
4. STATE
5. ZIP CODE
6. TELEPHONE # (Include Area Code)
7. PATIENT BIRTHDATE
8. SEX ☐ M ☐ F
9. INSURANCE COMPANY
10. POLICY NUMBER
11. DATE OF ACCIDENT
12. IS PATIENT'S CONDITION RELATED TO:
   - A. EMPLOYMENT? ☐ YES ☐ NO
   - B. AUTO ACCIDENT? ☐ YES ☐ NO
   - C. OTHER ACCIDENT? ☐ YES ☐ NO
13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (If different)

14. POLICYHOLDER'S NAME — Last / First / Initial
15. POLICYHOLDER'S ADDRESS (No. Street)
16. CITY
17. STATE
18. TELEPHONE # (Include Area Code)
19. ZIP CODE
20. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

21. NAME OF TREATING PROVIDER — Last / First / Initial
22. TAX I.D.
23. NPI
24. SPECIALTY
25. FACILITY OR OFFICE NAME
26. FACILITY /OFFICE ADDRESS (No. Street)
27. CITY
28. STATE
29. ZIP CODE
30. TELEPHONE # (Include Area Code)
31. EMAIL ADDRESS
32.. FAX # (Include Area Code)
33. INITIAL DATE OF TX
34. DATE OF LAST VISIT

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ MEDICATIONS ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTIC TEST ☐ EXISTING CONDITIONS ☐ COMORBIDITIES ☐ OTHER

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below) ICD Ind. ☐ 9 ☐ 10

A. ______ B. ______ C. ______ D. ______
E. ______ F. ______ G. ______ H. ______
I. ______ J. ______ K. ______ L. ______

37. CHECK APPROPRIATE CARE PATH (if applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

38. DATE(S) OF REQUEST

FROM MM	FROM DD	FROM YY	TO MM	TO DD	TO YY	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT Purchase	EQUIPMENT Rental	SPINAL INJECTION Unilateral	SPINAL INJECTION Bilateral	DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS

☐ INCLUDE SUPPORTING DOCUMENTS

FRAUD PREVENTION - NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39 ______________________________
SIGNATURE OF PROVIDER DATE

APTP FORM VERSION 2.1 (3/2016)