NO-FAULT UTILIZATION REVIEW
INSURER REPLY TO PROVIDER APPEAL

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Utilization Review Section
DIFS-URAppeals@michigan.gov
Fax: 517-763-0305

******All fields must be completed.******

Today's Date:	**DIFS Provider Appeal Case No:**
Date of Notice of Determination: **Note:** Mark N/A if no Determination was issued under R 500.64(1).	
Date of DIFS Notice of Appeal: **Note:** Insurer Reply is due within 21 days of this date.	
Total Dollar Amount of Denied Bill(s):	**Medical Review Organization:** **Note**: Mark N/A if not utilized.

I. INSURER INFORMATION

Insurer Name:	Insurer Contact (name of person completing this form):
NAIC Number:	Phone Number:
Mailing Address:	Fax Number:
	Email Address:
Claim Number(s):	Date of Accident:

II. INSURER REPLY TO PROVIDER APPEAL

Explain the named insurer's reasoning for denying the named provider bills, etc. regarding this appeal:

III. INFORMATION IN SUPPORT OF REPLY:

Please include with your reply any documentation in support of your determination that is being appealed by the provider. **Note:** As applicable, please include all documents related to requests for explanation exchanged between provider and insurer prior to this appeal request, pursuant to R 500.63.

List Documentation Provided:

IV. INSURER CERTIFICATION AND ACKNOWLEDGEMENTS

PLEASE DO NOT LOCK THE SIGNATURE BOX; DOING SO WILL RESULT IN THE REJECTION OF YOUR REPLY.

By signing this form, I understand and acknowledge that I will respond to the Department's inquiries regarding this appeal, and I certify that the information included on this form is correct and complete to the best of my knowledge and belief. I also understand and acknowledge that submitting false or misleading information is cause for rejection of this reply and may subject me and/or the insurer to penalties as provided by law.

Authorized Signature:	Date:
Printed Name / Title:	Email Address: