

Appeals Toolkit

**Turn Healthcare Insurance
Denials into Dollars**

Tammy Tipton

Contents

About the author	x
Chapter 1: Introduction	1
How this book will help	2
Providers' rights related to appeal review	3
Right to appeal	4
Right to act as the authorized representative of the patient and/or beneficiary	5
Right to pursue appeals without reprisal from carrier	7
Right to receive denials and complete information regarding adverse determination	7
Right to litigate	8
References	10
Chapter 2: Benefit Disclosure and Misquoted Benefits	11
Demanding benefit clarification disclosure	12
Using the Pretreatment Disclosure Request	14
Data quality and auditing	16
Inaccurate insurance information provided by patients during registration	16
Consumer protections related to COB	17
Inaccurate information provided by insurers during registration	18
Protecting your verification efforts	19
References	21
Chapter 3: Utilization Management	23
Tracking preauthorization response compliance	24
Tracking memos	25
Review and use of state utilization review mandates	29

Contents

Review and use of utilization review standards.....	29
Appealing carrier's failure to provide peer review within one day of denial	30
Appealing carrier's failure to provide written notice	31
Appealing carrier's duplicate or overly broad medical record requests.....	31
Appealing carrier's failure to abide by required deadline for decision	33
Demanding compliance with utilization review standards.....	33
References.....	35
Chapter 4: Medical Necessity	37
Defining medical necessity	37
Seeking a quality medical necessity review from payers.....	38
Demanding procedural fairness in medical necessity appeals	40
Component 1: Submission of medical records and inclusion of patient-specific clinical care citations.....	41
Component 2: Assessment of carrier's claim review procedures affecting denial	44
Component 3: Potentially applicable compliance/regulatory consumer protections	48
References.....	50
Chapter 5: Incorrect Payments	51
Disclosure of fee schedule information	52
Disclosure of payment calculation methodology	52
Incorrect modifier payment appeals	53
Disclosure of UCR payment calculation methodology	54
Submission of published coding standards.....	57
Incorrect contractual appeals/Silent PPO assessments	57
References.....	58
Chapter 6: Prompt Pay and Mandatory Coverage Laws	59
Prompt payment	59
Clean claim definition.....	60
Prompt payment violation sanctions	60
Mandatory coverage laws	61

Emergency treatment mandates	61
Newborns’ and Mothers’ Health Protection Act of 1996.....	63
Mental health treatment protections	63
Alternative/complementary care.....	65
References.....	67
Chapter 7: Treatment Exclusions and Limitations	69
Maximum benefit audit requests	69
Experimental treatment appeals	70
Treatment caps: Justifying extended care.....	73
Ensuring that the carrier is aware of dual-diagnosis issues	75
References.....	76
Chapter 8: Refund and Recoupment.....	77
Responding to refund requests.....	77
Timely action.....	78
Demanding disclosure of denial basis	81
Referring to law	81
Contesting the decision.....	82
Offering to pay on a “contingency basis”	83
References.....	84
Chapter 9: Level II Appeals and Beyond	85
Appealing twice	85
Citing compliance issues	86
Beyond appeals: Contract negotiation to resolve denial issues.....	87
Most commonly overlooked managed care contract issues.....	88
Request for managed care payer negotiation.....	92
References.....	93

Contents

Chapter 10: ERISA..... 95

Disclosure requirements and benefit claims procedure regulation	96
ERISA disclosure requirements	97
ERISA claims procedure regulation	99
Using ERISA claims procedure regulation to get a full and fair appeal review.....	100
ERISA benefit assignability.....	104
References.....	106

Chapter 11: Medicare Appeals 107

Claim response time.....	108
Initial determination	108
Level I: Redeterminations.....	108
Level II: Reconsideration.....	109
Reopenings	110
Level III: ALJ review	110
Level IV: Medicare Appeals Council and Federal District Court	111
Medicare coding appeals	111
Geriatric treatment and medical necessity issues	111
References.....	114

Appendix: Sample Letters 115

Sample Letter A: Pretreatment Request for Benefit Disclosure.....	117
Sample Letter B: Coordination of Benefits Appeal	119
Sample Letter C: Misquoted Verification of Benefits Appeal.....	120
Sample Letter D: Request for Peer-to-Peer Conversation—URAC.....	121
Sample Letter E: Lack of Written Decision—URAC.....	122
Sample Letter F: Overly Broad Medical Records Request Response—URAC.....	124
Sample Letter G: Lack of One-Day Response—URAC	126
Sample Letter H: Level II Appeal—Unsatisfactory Reviewer ID/Qualifications Appeal.....	128
Sample Letter I: Level II Appeal—Unsatisfactory Use of Written Criteria Appeal/ Geriatric Patients.....	130

Sample Letter J: Request for Expert Review—ERISA 132

Sample Letter K: Request for Review by Certified Coder 134

Sample Letter L: Request for CCI Compliance..... 135

Sample Letter M: Request for E/M Modifier –25 Review..... 136

Sample Letter N: Silent PPO..... 137

Sample Letter O: Lack of Precertification Appeal—Prudent Layperson Standard..... 138

Sample Letter P: Maximum Benefit Appeal—Request for Newborns’ and Mothers’
Health Protection Act of 1996 Compliance 139

Sample Letter Q: Maximum Benefit Appeal—Request for U.S. Mental Health
Parity Act Compliance..... 141

Sample Letter R: Maximum Benefit Appeal—Request for Audit of Paid Claims 143

Sample Letter S: Lack of Precertification—Experimental/Investigational Appeal..... 144

Sample Letter T: Refund/Recoupment Request Response..... 145

Sample Letter U: Refund/Recoupment URAC Protections..... 146

Sample Letter V: Managed Care Contract Renegotiation Request..... 148

Sample Letter W: Pretreatment Request for Summary Plan Description..... 150

Sample Letter X: Lack of Precertification on ERISA Urgent Care Claim 152

Sample Letter Y: Medicare Level I Redetermination or Level II Reconsideration
Medical Necessity..... 154

Healthcare organizations now keep a well-trained eye on their denied claims, looking for clues to what carriers are paying, stalling, or denying this quarter.

Denied claim reports give managers extensive information regarding how well the registration, utilization/case management, and patient financial services departments are functioning. However, in the shorter-term view, denied claims simply beg for immediate attention. Denials once written off or moved to patient responsibility are now sitting in a queue awaiting your attention. You must initiate these appeals within impending payer-specified deadlines. You have to gather all relevant information and develop a persuasive argument. Furthermore, many of these denied claims involve ambiguous contract and payment terms upon which you and the payer hold sharply divided views and perspectives.

Now that healthcare organizations have undertaken the task of managing denials, the real challenge is to do so professionally and effectively. This book provides the necessary information to take control of appeals.

The ongoing challenge is to determine why one appeal works and another fails. Inevitably, healthcare organizations find that some carriers respond to appeals professionally and others will not respond at all. As so often happens, the effectiveness of the organization's denial management efforts depends on developing effective strategies for circumstances commonly viewed as beyond your immediate control, such as carrier nonresponse and poor contracting ramifications. Ongoing staff training with constant attention to incorporating and securing legal protections through appeals can be a large asset in dealing with problematic appeal review. Simple form letter appeals often don't accomplish high rates of recovery.

Educational resources and training are increasingly important for effective denial management. Organizations with insufficient training and staffing for the scope of the project will generally fall back on rebilling denied claims en masse. The result of rebilling a previously rejected claim is a ballooning of accounts on the denied claim report and no revenue to show for the extra effort. For better-prepared organizations, initial appeal efforts on identified

Chapter 1

accounts were positive; however, even these organizations over time often experienced a drop in claim recovery.

Furthermore, carrier claim review policies have not remained stagnant while providers geared up to appeal denials. Instead, carriers have strengthened contract language, giving them greater discretion over network claim adjudication, and they have implemented efforts to better control large-balance out-of-network liabilities, such as direct payment to policyholders and drastic usual, reasonable, and customary reductions.

Most healthcare organizations are pleased with the better communication, coordinated effort, and accountability, which, as a result of denial management efforts, affect every medical claim sent out. Yet the consensus of many involved in denial management is that ongoing claim recovery is both challenging and ever-changing. Once a scenario is identified that results in numerous appeals, those who are tasked with solving the problem are often caught between the two opposing goals of providing the quality that healthcare patients expect and providing care at the efficiencies demanded of payers. Healthcare organizations find themselves in the often adversarial role of arguing over coverage technicalities and ambiguities involving medical necessity, correct coding, and contract interpretation, which used to be the task of

the patient's attorney. The success of denied claim negotiations and appeals often has repercussions for future claims. It is extremely important that these efforts are not in vain but are undertaken in the most professional, most effective manner possible.

In the end, denial management does not automatically equate to benefit recovery. Effective appeals result in denied claim recovery. Effective appeals result from knowing your organization's legal rights, understanding the payer's rights, and finding ways to resolve differences without compromising the quality and efficiency necessary for everyone.

How this book will help

Many appeal letter forms circulate among healthcare providers. Unfortunately, appeal responses often vary in terms of quality in direct proportion to the quality of the appeal. Simply put, a form letter type of appeal will often garner a form letter rejection. This book contains numerous tips for avoiding generating a form letter appeal, and extensive instructions on developing a customized argument are provided.

Second, appeal letters often fail to demand disclosure of the basis claims denial. Although this information may or may not be favorable, obtaining complete denial information is critical to developing your Level II appeal or,

alternatively, determining how to proceed with future claims of that nature.

Lastly, this book will discuss upper-level appeal efforts and how to improve success by exercising all levels of appeals. Legal rights and responsibilities are at the crux of most appeals, but provider appeals typically focus on clinical issues alone without sufficient discussion of compliance issues. Each chapter includes a complete discussion of potentially applicable compliance issues and how to use such information in appeals.

Providers' rights related to appeal review

Medical providers who file appeals on behalf of their patients provide a valuable service and often resolve issues that patients are not in a position to effectively and promptly resolve. Prior to managed care, providers' rights under traditional health insurance were actually very limited. Insurance carriers often reviewed provider-initiated appeals, and even acted upon them, only as a courtesy to their policyholders. But if the denial was maintained and the provider proceeded to court over the lack of claim payment, it was the court that actually raised the issue of the provider's lack of appeal rights. Time and time again, health providers litigating for insurance benefits were denied their day in court because the court ruled that the medical provider could hold only the patient responsible

for payment of outstanding medical claims. Because the insurance carrier's contractual arrangement was with the patient, only the patient had "legal standing" to litigate against the insurer over contractual breaches such as incorrect denials.

Managed care significantly changed the nature of insurance litigation and, in many ways, complicated coverage terms exponentially by introducing many barriers to coverage, such as precertification, referral, and other network arrangements. Although providers now had a contractual arrangement formalizing their relationship with the payer, an insidious deterrent to litigation was made a part of this contractual arrangement in the form of arbitration agreements. Under managed care, providers secured more clearly defined appeal rights but often at the cost of waiving the right to litigate disagreements. Although arbitration and mediation provide a venue for dispute resolution, the decisions reached in such settings are private, do not necessarily apply to future related claims made by that provider or any other provider, and certainly do not set a legal precedent with the power to shape future healthcare litigation.

During the past decade, many state and federal healthcare mandates have recognized the role of the medical provider in initiating treatment appeals. Provider appeal rights were broadened

Chapter 1

in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and in the group health area, the Employee Retirement Income Security Act of 1974 (ERISA) Benefit Claims Procedure Regulation clarified the rights to providers to appeal urgent care claims. Yet the ability to pursue appeals has not necessarily been coupled with the ability to pursue litigation for poor-quality appeal review and response on the part of the carrier.

Providers still find their efforts stymied by the complexities that dictate appeal rights and, more importantly, the right to litigate. Insurance carriers often process provider appeals differently from patient appeals and may not provide the full range of options to providers that are extended to a beneficiary who has a clearer avenue to litigate.

As might be anticipated, insurance carriers are receptive to clinical appeals submitted by the healthcare organization seeking to clarify the treatment plan and justification for care rendered. Furthermore, most providers have options for getting medical necessity denials reviewed by unbiased reviewers in the form of independent review; however, many appeals relate to legal protections involving authorizations, verification issues, contractual obligations, and specific policy and benefit plan terms and conditions. Payers exercise wide discretion in policy or plan language interpretation knowing that these issues are often not subject to

independent review and may also not be litigated by providers due to arbitration clauses and other barriers to provider litigation.

One of the most basic protections affecting the quality of the appeal process is full disclosure of the basis of the claim decision. Carriers often refuse to provide disclosure of requested claim file information or access to upper-level appeals until the provider has demonstrated a legal right to access such information. Access to this level of detail is crucial to the success of your appeal efforts.

Understanding your legal rights to appeal, demand disclosure of denial information, and pursue action beyond appeals is necessary to overturn unfair denials and determine the appropriate course of action when appeal efforts fail.

Right to appeal

Insurance carriers frequently take the position that the beneficiary is the party with the broadest appeal rights. Although your appeals may be accepted and reviewed, pertinent claim information may be withheld if you fail to clarify your authorization to pursue the appeal on behalf of the beneficiary.

An Assignment of Benefits (AOB) is the most widely used form for securing both the right to receive benefit payment and the right to pursue appeals if claims are denied. A correctly worded

AOB can broaden your rights to a full and fair review of an adverse determination. Many claim processing protections are designed to protect the insured, and providers seeking these protections, such as complete disclosure of the denial details, may be told they do not have the right to act on behalf of the insured party. To clarify the providers' rights, an AOB should specifically grant you the right to act as the authorized representative for purposes of appeal and assign and transfer all rights under the policy to you. This documentation can be attached to every appeal in order to clarify your rights.

The exact wording of the authorization of representation or AOB, however, can play a key role in just how far you can go to resolve the disagreement. The U.S. Department of Labor has indicated that many medical providers obtain only an "authorization to receive payment" rather than a legally compliant "assignment of benefits." An authorization to receive payment often allows carriers to simply redirect benefit payments to your office. A true AOB, however, gives you much more legal authority to pursue payment and may even allow your office to litigate on behalf of the beneficiary. There are many legal distinctions between these two different forms and your organization needs to assess your own forms to determine what rights it grants and what limitations it has related to appeals; however, either of these forms can be improved with a clause which designates

your organization to act as the authorized representative for any subsequent appeals related to benefit denials.

Right to act as the authorized representative of the patient and/or beneficiary

Both the Centers for Medicare & Medicaid Services and the U.S. Department of Labor have clarified the importance of allowing beneficiaries to designate an authorized representative for the purposes of appeals. In some situations, such as seeking authorization in emergency situations, the treating physician is often recognized as the authorized representative without the need for any particular designation. Under Medicare, providers who accept assignment of an individual claim have standing to appeal, but post-service private insurance and group health appeals may require a formal designation, particularly if the physician is seeking complete disclosure of the claim file and related claim documentation.

There is extensive information on acting as an authorized representative of the beneficiary when pursuing an appeal involving an ERISA employer-sponsored benefit plan, found at the Department of Labor Employee Benefits Security Administration Web site (www.dol.gov/ebsa). The ERISA Benefit Claims Procedure Regulation addresses the right to appoint an authorized representative for appeals but stipulates that the AOB may not suffice.

The following information is the DOL Employee Benefits Security Administration FAQ page regarding designation of an authorized representative:

FAQ B-2: Does an assignment of benefits by a claimant to a healthcare provider constitute the designation of an authorized representative?

EBSA Response: No. An assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan. Typically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

FAQ B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?

EBSA Response: Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant's authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.

(Source: www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)

Based on this information, your assignment must include an authorized representative designation to be effective for appeals, or contain specific wording to meet the legal requirements for a “true” assignment and transfer of plan benefits. If the designation is not part of the AOB, it can be secured after treatment on an as-needed basis.

Right to pursue appeals without reprisal from carrier

Physicians who advocate for medically appropriate healthcare for their patients are generally protected from retaliation by state managed care reforms. In the mid-1990s, the American Medical Association accused a number of HMOs of having contract language that limited communication between physicians and patients regarding treatment options. As a result, state after state included in their managed care reforms language to specifically protect the right of physicians to disclose information to patients about their medical conditions and treatment options and protections related to treatment advocacy.

Managed care contracts continue to have broad deselection language in them, however. The article “Patient Advocacy and Termination” from the Nebraska Law Review (2003, 508) states that more than fifteen states have enacted laws declaring that healthcare professionals cannot be terminated from or otherwise penalized by

managed care organizations because of their advocacy. But the author, Linda Fentiman, identifies numerous obstacles to enforcement even in those states with such advocacy protections. This article is available online at <http://digitalcommons.pace.edu/lawfaculty/323/>.

Right to receive denials and complete information regarding adverse determination

You can’t appeal a denial that you do not understand. Unfortunately, providers are routinely denied access to claim denial details. A number of consumer protections require carriers to release such detail upon request.

For example, the ERISA Benefit Claims Procedure Regulation, which applies to most employer-sponsored benefit plans, requires carriers to disclose certain documents and information used in making a claim determination. This protection is very important because you can use it to obtain access to internal clinical criteria, fee schedules, and usual, customary, and reasonable charge data used to adjudicate and calculate claims. Although these protections apply to beneficiaries, they can extend to other qualified parties, such as an authorized representative, if the request is made in compliance with the regulation.

The following information is the EBSA FAQ page regarding this subject:

FAQ C-17: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?

EBSA Response: Yes. It is the view of the department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. The department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries. See §§ 2560.503-1(g)(v) (A) and (j)(5)(i); 65 FR at 70251. Also see §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996).

(Source: www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)

Right to litigate

Although appeals may be widely available to providers, the quality of the appeal process is not guaranteed. The quality of the appeals process provided by the carrier depends on a number of variables, including the credentials of the reviewers, the ability to present new information related to the claim, and the availability of information used in reaching the decision, such as internal rules, guidelines, and protocols; however, in the absence of

professional standards and transparency in the process, one of the most important rights that require assessment is the right to appeal to an independent review organization and, even more important, the ultimate option of litigation before a judge or jury.

Many managed care contracts specify in clear, nonnegotiable terms the dispute resolution venue to be used in the event of a disagreement among contracting parties. Dispute resolution

options, which may be referenced in the contract, range from mediation or arbitration to litigation in a court of law. Often, litigation is specifically prohibited under managed care contracts. Although your contract may include such wording, always consult an attorney at the time of any disagreement to discuss the full implications of this agreement and how breach of contract on the part of the carrier may affect this clause.

An attorney would be able to determine whether your AOB would allow you to litigate as a beneficiary of the insurance claim rather than as a provider. Medical claims must be processed in compliance with the agreed-upon terms in both the provider's managed care contract and the insured's benefit contract. If the dispute involves the insured's benefit terms, the provider may be able to bring suit on behalf of the patient as a third-party assignee. Assignee litigation is an important option to consider because different laws and penalties apply to a carrier's failure to process benefits in accordance with the insurance policy. Furthermore, the right to litigate in court as an assignee is not necessarily prohibited by the arbitration/mediation terms of the participating provider contract.

Assignee litigation can be tricky to pursue for a number of reasons. First, assignments of healthcare benefits vary a great deal in their terms and may not meet state and federal

requirements necessary for a true "assignment and transfer" of rights under the policy. Legal requirements regarding AOB wording vary from state to state, so you should seek local legal counsel input when altering the AOB. When you discuss this with your attorney, be sure to explain that, for appeal purposes, the assignment needs to actually transfer rights, including the right to litigate, to your organization. Typically, the AOB will feature the words "irrevocably assign and transfer all rights, title and interest in the benefits payable for services rendered provided in the referenced policy or policies of insurance or benefit and welfare plan benefits." You should also seek input on protecting your organization by using language that would indicate you are under no obligation to pursue any right or recovery. A separate Designation of Authorized Representative is also helpful in clarifying your appeal rights. We recommend the following wording for the designation section:

*Designation of Authorized Representative—
I hereby designate this medical provider
or practice to act as my representative
during an insurance or plan benefits
appeal in the event of a coverage denial.
I understand that this medical provider or
practice has the right to decline or accept
this designation at the time a denial is
received. If this medical provider or practice
accepts this designation, the outcome of
any appeal is not guaranteed, and I agree to*

Chapter 1

pay all charges that remain unpaid by the insurance carrier or benefit plan regardless of the outcome of any appeal.

Although an assignment is routinely obtained from patients, it is rarely provided to the insurance carrier when claim-related communications ensue. It is important to advise carriers of the assignment and to provide a written copy of the assignment in order to fully establish your rights.

Some health insurance contracts prohibit an AOB by including an “anti-assignment” provision. If the health benefits are simply not assignable, any assignment given by the patient would be void. Courts have differed in upholding anti-assignment provisions and have even refused to recognize anti-assignment provisions in some instances. However, the best protection for providers is to attempt to clarify the assignability

of insurance benefits when benefits are verified. If the insurance company fails to notify a provider of the anti-assignment provisions when specifically asked, this provision may be discarded in litigation because it was not properly disclosed.

Lastly, many health insurance lawsuits have been thrown out of court because the available appeals were not exhausted. It is important to keep in mind that the carrier appeals are often a prerequisite to litigation. If they are skipped, courts may rule that the litigant did not follow the proper procedures outlined in the policy or plan documents. Chapter 2 has more detailed information about benefit clarification and how to obtain information about the assignability of insurance benefits. Subsequent chapters provide extensive information to allow you to meet the requisite number of appeals while raising pertinent compliance issues.

REFERENCES

FAQs about the Benefit Claims Procedure Regulation. U.S. Department of Labor, www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

Fentiman, L. 2003. “Patient Advocacy and Termination.” *Nebraska Law Review*. 82: 508.

HCPro

Order your copy today!

Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit www.hcmarketplace.com. If you received a special offer or discount source code, please enter it below.

Title	Price	Order Code	Quantity	Total
				\$
Your order is fully covered by a 30-day, money-back guarantee.			Shipping* (see information below)	\$
			Sales Tax** (see information below)	\$
			Grand Total	\$

Enter your special Source Code here:

Name

Title

Organization

Street Address

City

State

ZIP

Telephone

Fax

E-mail Address

***Shipping Information**

Please include applicable shipping. For books under \$100, add \$10. For books over \$100, add \$18. For shipping to AK, HI, or PR, add \$21.95.

****Tax Information**

Please include applicable sales tax. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

BILLING OPTIONS:

Bill me Check enclosed (payable to HCPro, Inc.) Bill my facility with PO # _____

Bill my (✓ one): VISA MasterCard AmEx Discover

Signature

Account No.

Exp. Date

(Required for authorization)

(Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at www.hcmarketplace.com

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945

CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787

FAX THE COMPLETED ORDER FORM TO: 800/639-8511

E-MAIL: customerservice@hcpro.com

© 2008 HCPro, Inc. HCPro, Inc. is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks. Code: EBKPDF

P.O. Box 1168 | Marblehead, MA 01945 | 800/650-6787 | www.hcmarketplace.com