10A NCAC 22J .0102 PETITION FOR RECONSIDERATION REVIEW

(a) A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement, and adjustments. A provider may request a reconsideration review within 60 calendar days from receipt of notice of an institutional reimbursement rate. Final notification of payment, payment denial, disallowances and payment adjustment mean that all administrative actions necessary to have a claim paid have been taken by the provider and the Division or the fiscal agent has issued a final adjudication. If no request is received within the respective 30 or 60 day periods, the Division's action shall become final.

(b) A request for reconsideration review shall be in writing and signed by the provider or the provider's representative and contain the provider's name, address, and telephone number. It shall state the specific dissatisfaction with the Division's action and should be mailed to: Appeals, Division of Health Benefits, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501.

(c) The provider may appoint another individual to represent him. A written statement setting forth the name, address, and telephone number of the representative so designated shall be sent to the address listed in Paragraph (b) of this Rule. The representative may exercise any rights given the provider in the review process. Notice of meeting dates, requests for information, or hearing decisions shall be sent to the authorized representative. Copies of such documents shall be sent to the petitioner only if a written request is made.

History Note: *Authority G.S. 108A-25(b); 108A-54; 42 U.S.C. 1396b; 42 C.F.R. 455.512;*
Eff. January 1, 1988;
Readopted Eff. July 1, 2018;
Amended Eff. March 1, 2020.