

PAYOR WARS.
FIGHTING
BACK - A
LAWYER CFO'S
PERSPECTIVE

Introduction – Pete Young

Background and History

- University of Wyoming
 - Undergraduate – 1987 – Bachelors of Science in Business/Accounting
 - Law School – 1990 – Juris Doctorate in Law

Private Law Practice 1990 – 2017

- Expertise – Physicians, hospitals, pharmacy, billing, collections

Post Law Practice

- Davita Medical Group
- Insurance Office of America
- Patient Direct Rx
- Nomi Health
- Community Hospital (Grand Junction, CO)

Payor Wars

Unprecedented Times

- Delay, Delay, Delay
- Deny, Deny, Deny
- Defend, Defend, Defend



Payor Wars

United Healthcare Insurance

- Brian Thompson (CEO)
- Public response and outcry
- Artificial Intelligence
- “Take or Leave it” contracts with payors
- Favorable terms that allow payors to unilaterally change contracts via policy changes
- Time and expense of chasing
 - Claims \$100-\$1,500
 - Claims less than \$100
 - Venipuncture
 - Blood Draws
 - Wound Care

UnitedHealth Now Has 1,000 AI Use Cases, Including in Claims

But artificial intelligence on its own will never deny a claim, assures the insurer's chief digital and technology officer

By Isabelle Bousquette [Follow](#)

May 5, 2025 9:00 am ET



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Resize



9



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More than 90% of the claims UnitedHealth processes every year are auto-adjudicated—meaning that software automates a decision based on the information provided. PHOTO: PATRICK T. FALLON/AGENCE FRANCE-PRESSE/GETTY IMAGES

Delay, Deny and Defend

Be Aggressive

Be Proactive

but

Be Right

- clean claims
- properly pre-authorized
- properly coded
- medical necessity checked and validated pre-care
- properly documented from a medical standpoint
- properly “statused” by hospital clinical improvement

Delay, Delay, and more Delay

Medical Record Requests – How many times is enough?

- 30 days to process claim – Colorado Revised Statutes Title 10. Insurance § 10-16-106.5
 - Itemized statement +30 days
 - Medical records +30 days
 - More medical records +30 days
 - either they don't receive (lost/missing)
 - HIPAA response (see example letter)
 - Delay then deny for medical necessity
 - Pay without interest – Colorado Law mandates interest
See Colorado Revised Statutes Title 10. Insurance § 10-16-106.5

Carrier Info

Address

Re: Member ID:
Patient Name:
Account Number/CSID Number:
Dates of Services
Claim Number:

Dear _____ Claims:

Community Hospital provided medical services to your insured on _____ through _____. As of this date, the expenses incurred have not been paid, despite the fact that UMR has been provided all of the necessary supporting materials from Community Hospital.

To facilitate payment and pursuant to the request of _____, Community Hospital provided the patient's complete medical records to _____ on _____ and _____. The confirmation numbers that show that _____ did in fact receive the medical records on both occasions. The confirmation numbers are _____ and _____.

_____ has now advised Community Hospital that it does not possess the records, despite written confirmation that it indeed received them on two separate occasions. We know that _____ received the records; we have confirmation of this. You are now advising us that you do not possess the records. The only plausible answer or excuse is that you have lost or misplaced this important patient protected health information. This is a potential violation of the patient's privacy and rights protected by HIPAA.

Within 7 days please advise us that you have located the records or we will be obligated to notify the patient that you have lost their protected health information.

Please reach out to the undersigned to confirm the updated status and research of this issue. Your prompt attention to this matter is required.



Peter J. Young, Esq.

Post Medical Record Follow-Up

30 – 60 – 90 – 120 – Day Delays

- Demand Compliance (***Be Right***)
- Records provided; services provided
- ***File is complete***
- Demand for payment (*see example*)

Carrier info

Address

Re: Outstanding payment for _____.

Dear Sirs:

Community Hospital provided medical services to your insured on _____ and through _____. As of this date, the expenses incurred have not been paid, despite the fact that you have been provided all of the necessary supporting materials.

Your patient file is complete and it has been since _____.

Colorado law requires that a carrier pay a properly supported healthcare bill promptly and no later than 30 days from the date received. See, Colo. Rev. Stat. 10-16-106.5. Moreover, the failure to pay obligates you to pay applicable interest and penalties. See, Colo. Rev. Stat. 10-16-106.5.

The time to resolve this matter is now. Continued delay constitutes bad faith and violates Colorado law.

Demand is hereby made that you pay the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

Thank you.



Peter J. Young, Esq.

Date:

Carrier Information

Colorado West Healthcare System
2351 G Road
Grand Junction, CO 81505
NPI: 1497723407

Member ID:

Patient Name:

Account Number:

Dates of Services:

Claim number:

Carrier info

Address

Re: Outstanding payment for _____

Dear Sirs:

Community Hospital provided medical services to your insured on _____ and through _____. As of this date, the expenses incurred have not been paid, despite the fact that you have been provided all of the necessary supporting materials.

Your patient file is complete and it has been since _____. We have provided you complete records on _____ and have confirmation of receipt, which specifically includes _____.

Colorado law requires that a carrier pay a properly supported healthcare bill promptly and no later than 30 days from the date received. See, Colo. Rev. Stat. 10-16-106.5. Moreover, the failure to pay obligates you to pay applicable interest and penalties. See, Colo. Rev. Stat. 10-16-106.5.

The time to resolve this matter is now. Continued delay constitutes bad faith and violates Colorado law.

Demand is hereby made that you pay the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

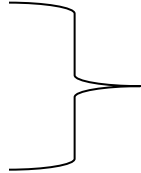
Thank you.



Peter J. Young, Esq.

Deny, Deny, and Deny

Other “bologna” denials

- Out of Network
 - Wrong NPI numbers
 - No pre-authorization when there is one on file
 - The “promise to pay” or “check in the mail”
- 
- Remember – ***BE RIGHT***

Carrier:

Address:

Re: Out of Network Issues

Dear Sirs:

Community Hospital has been in network since the inception of the contract with _____ on or about _____. We have been notified that Community Hospital has been deemed "Out of Network" causing a crucial impact on the ability to obtain pre-authorizations to provide our patients their medical care. This is not true and is causing a substantial monetary loss for Community Hospital as a whole organization. This situation continues to cause problems with Community Hospital preauthorizing services through these third-party entities and causes denial of care or delayed care for our patients.

Community Hospital has complied your contractual requirements. Your agent or third-party vendors are denying authorizations based on the erroneous conclusion that we are out of network violates Colorado Law and your contractual commitments to us.

Moreover, Community Hospital has been receiving denials due to _____ stating "Out of Network" even though we have been in network since inception of the contract. This has caused patient complaints, a denial and delayed care and has also steered business away from Community Hospital all together. This too violates your contractual commitment to us.

This situation requires immediate action and correction including a confirmation in writing that Community Hospital is in fact in network and that the pre-authorizations for the designated services will be processed despite the baseless out of network notification.

Peter J. Young, Esq
Chief Compliance Officer/Privacy Officer
(970) 644-3030

Carrier info

Address

Re: Outstanding payment for _____.

Dear Sirs:

Community Hospital provided medical services to your insureds identified on the attached spreadsheet. As of this date, the expenses incurred have not been paid, despite the fact that you have been provided all of the necessary supporting materials.

Your patient files are complete and you have all the required documentation from Community Hospital in order to pay the invoices. These charges were submitted timely, yet have not been paid. You have advised that the claims are being denied or reduced due to the incorrect NPI number. Community Hospital and the subject provider have had the same NPI number for years. The NPIs have not changed. The only explanation for this situation is that your system and process has generated the wrong NPI. Relying on your own system error to justify a denial or reduction is bad faith claims handling.

Colorado law requires that a carrier pay a properly supported healthcare bill promptly and no later than 30 days from the date received. See, Colo. Rev. Stat. 10-16-106.5. Moreover, the failure to pay obligates you to pay applicable interest and penalties. See, Colo. Rev. Stat. 10-16-106.5.

The time to resolve this matter is now. Continued delay constitutes bad faith and violates Colorado law.

Demand is hereby made that you pay the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event, I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

Thank you.



Peter J. Young, Esq.

Date

**Payor
Address**

Colorado West Healthcare System (CWHHS)
2351 G RD
Grand Junction, CO 81505
NPI: 1497723407

Member Information

Re: Formal Demand for Payment of Outstanding Billed Charges

Dear Sirs:

Community Hospital has regularly contacted you, _____, in regard to _____ for the outstanding balance for the following claim and insured. During these communications you have promised and represented that the claim has been paid and funds have been "released." Despite this representation and promise, Community Hospital has not received reimbursement for billed charges. The balance remains outstanding as of _____ in the amount of _____.

We have carefully audited our accounts receivable and payment systems and certain that the funds have not been received. Moreover, _____ has not provided any additional explanation as to why the funds are being delayed.

Demand is hereby made that you release the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

Thank you.

Peter J. Young, Esq
Chief Compliance Officer/Privacy Officer
(970) 644-3030

Carrier info

Address

Re: Outstanding payment for _____.

Dear Sirs:

Community Hospital provided medical services to your insureds identified on the attached spreadsheet. As of this date, the expenses incurred have not been paid, despite the fact that you have been provided all of the necessary supporting materials.

Your patient file is complete and you have all the required documentation from Community Hospital in order to pay the invoice. These charges were submitted timely. You are denying this claim based on a lack of "pre-authorization." You take this position despite the fact that you did in fact provide prior authorization. A copy of that authorization is attached to this letter. Denying a claim for no pre-authorization when your own vendor or system show that you did authorize the service is baseless and a bad faith denial.

Colorado law requires that a carrier pay a properly supported healthcare bill promptly and no later than 30 days from the date received. See, Colo. Rev. Stat. 10-16-106.5. Moreover, your failure to pay obligates you to pay applicable interest and penalties. See, Colo. Rev. Stat. 10-16-106.5.

The time to resolve this matter is now. Continued delay constitutes bad faith and violates Colorado law.

Demand is hereby made that you pay the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

Thank you.



Peter J. Young, Esq.

Date

Carrier Info

Colorado West Healthcare System (CWHS)
2351 G Road
Grand Junction, CO 81505
NPI: 1497723407

Re: Failure to pay for authorized treatment and demand for immediate payment.

Dear Sirs:

Colorado West Healthcare System dba Community Hospital provided medical services to your insured, _____ on _____ through _____. On _____, Community Hospital obtained from _____ the inpatient authorization for the medical services provided. Based on this authorization, Community Hospital provided medically necessary medical services. A clean and timely claim was submitted to _____ on _____. A corrected claim was also submitted on _____ for a reduction in charges.

Despite obtaining proper authorization, Community Hospital received a denial from _____ stating that there was no preauthorization. **This denial occurred despite the fact that an authorization was provided by _____ with an authorization number of _____ and _____.** Community Hospital has followed all proper procedures and guidelines for obtaining the inpatient authorization along with providing all requisite documentation including an itemization of services, emergency medical records, progress notes, and radiology lab/results.

Your insured, _____ received the approved and authorized services at Community Hospital, which are covered by the insurance plan. The treatment was properly authorized by you or your agent. Despite this and having been provided the authorization, you have failed to pay the claim. This is a violation of the written agreement between Community Hospital and _____ and is also bad faith claims handling, a violation of the insurance code.

Under the contract between Community Hospital and _____ has a contractual obligation to immediately provide payment, which is due and owing.

Community Hospital now formally demands payment from _____ in the amount of _____. If payment is not received within 30 days of the date of this letter, Community Hospital will pursue arbitration under the contract and further report this conduct to CMS or the Department of Insurance, as appropriate and permitted.

Community Hospital reserves all rights under contract, at law and in equity.

Thank you,

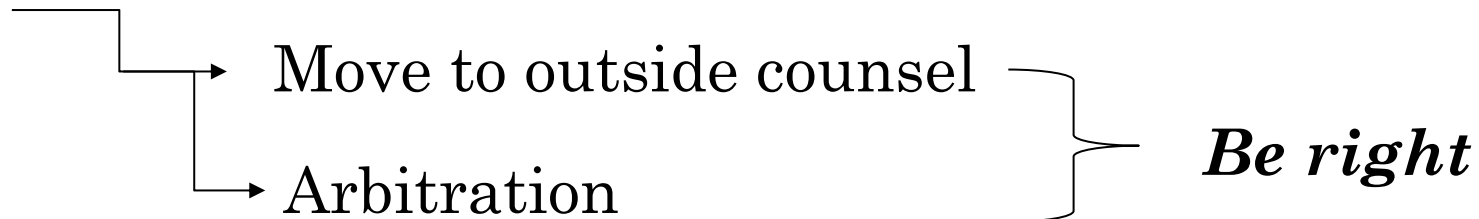
Peter J. Young, Esq
Chief Compliance Officer/Privacy Officer
(970) 644-3030

Deny, Deny, and Deny

Timeliness

- 30 – 60 – 90 – 120 – 180 (*Be right*)
- Time has expired
- Appeals have lapsed or expired

Appeals Exhausted



Carrier info

Address

Re: Outstanding payment for _____.

Dear Sirs:

Community Hospital provided medical services to your insured on _____ and through _____. As of this date, the expenses incurred have not been paid, despite the fact that you have been provided all of the necessary supporting materials.

Your patient file is complete and it has been since _____. We have provided you complete records on _____. In addition, we have timely filed appeals in an effort to resolve this matter without success. Regardless of the appeal, payment for services is still due. Specifically, and as stated in the prior appeal,

Colorado law requires that a carrier pay a properly supported healthcare bill promptly and no later than 30 days from the date received. See, Colo. Rev. Stat. 10-16-106.5. Moreover, the failure to pay obligates you to pay applicable interest and penalties. See, Colo. Rev. Stat. 10-16-106.5.

The time to resolve this matter is now. Continued delay constitutes bad faith and violates Colorado law.

Demand is hereby made that you pay the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

Thank you.



Carrier info

Address

Re: *Outstanding payment for* _____.

Dear Sirs:

Community Hospital provided medical services to your insureds identified on the attached spreadsheet. As of this date, the expenses incurred have not been paid, despite the fact that you have been provided all of the necessary supporting materials.

Your patient files are complete and you have all the required documentation from Community Hospital in order to pay the invoices. These charges were submitted timely, despite your unfounded statements to the contrary. Simply stated, the denials for timeliness are baseless.

Colorado law requires that a carrier pay a properly supported healthcare bill promptly and no later than 30 days from the date received. See, Colo. Rev. Stat. 10-16-106.5. Moreover, the failure to pay obligates you to pay applicable interest and penalties. See, Colo. Rev. Stat. 10-16-106.5.

The time to resolve this matter is now. Continued delay constitutes bad faith and violates Colorado law.

Demand is hereby made that you pay the full amount of the claim in the amount of _____ within 30 days of the date of this letter. In the event I do not hear from you within this time period, I will have no other alternative than to refer this to outside counsel for further handling.

Thank you.



Peter J. Young, Esq.

Contractual Rights

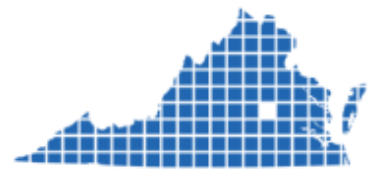
- Contract of adhesion
- We are stuck with it; “take it or leave it” contracts
- Contract is construed against the carriers when there is an ambiguity

Contractual Limitations

- Timeliness Applies both ways – 6 month/1 year limitation
- Take-backs – most contracts limit this to one year
- Recoupment – similar contractual limitation
 - Does this stop them? Of course not.
 - But there's a letter for that too.
- Order of Preference
 - Contract over policy changes; priorities in language
 - Default to Medicare rules when a conflict in terms exist

AI – Down Coding

- Automatic down coding is inappropriate
- Algorithms don't focus on problem physicians or providers
- Down coding is done without notice
- No education to address problem providers
- Down coding that occurs without record review is improper and illegal
- Most payors don't notify provider, but rather simply down code
- Unfairly burdensome to require documentation be provided on routinely down coded claims



Virginia College of
Emergency Physicians

JUN
27

*Judge rules in favor of physicians, hospitals in
federal Downcoding lawsuit*

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

VIRGINIA HOSPITAL & HEALTHCARE
ASSOCIATION,

THE MEDICAL SOCIETY OF VIRGINIA, and

VIRGINIA COLLEGE OF EMERGENCY
PHYSICIANS,

Plaintiffs,

v.

KAREN KIMSEY, in her official capacity as Director
of the Virginia Department of Medical Assistance
Services,

Defendant.

Civ. No. _____

VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs Virginia Hospital & Healthcare Association (VHHA), The Medical Society of Virginia (MSV), and Virginia College of Emergency Physicians (VACEP) bring this complaint against defendant Karen Kimsey, in her official capacity as Director of the Virginia Department of Medical Assistance Services (DMAS), and allege as follows:

INTRODUCTION AND NATURE OF THE ACTION

1. This case centers on the Virginia General Assembly's decision, in the midst of a global pandemic, to shortchange by tens of millions of dollars those hospitals and physicians who treat Medicaid patients. That counterproductive decision will cause irreparable harm not only to needy patient populations, but also to hospitals and physician practices themselves, which are already struggling with increased costs and decreased revenue due to the challenges of the COVID-19 pandemic. The state's taking of earned revenue will impair providers' ability to deliver care to patients, at a time when the public is counting on hospitals and doctors more than ever.

TeamHealth wins \$60 mln in underpayment suit against UnitedHealthcare

By Brendan Pierson

December 8, 2021 3:34 PM MST · Updated 3 years ago



Aa



UnitedHealthcare loses lawsuit to TeamHealth — again — in ongoing battle over billing

Published Dec. 2, 2022



Rebecca Pifer
Senior Reporter

UnitedHealth Group

Dive Brief:

- UnitedHealthcare has lost another legal fight with TeamHealth in the latest billing salvo between the nation's largest payer and the private-equity backed provider group.
- A three-judge arbitration panel in Florida ruled this week that UnitedHealthcare underpaid a TeamHealth clinician group from 2017 to 2020, and awarded \$10.8 million to TeamHealth. TeamHealth also expects an "additional award of millions of dollars" in prejudgment interest and costs, according to a release.

July 18, 2022

Members of the Delegation,

On behalf of the American College of Emergency Physicians (ACEP) and the 40,000 members we represent, we write to express our deep concern with Anthem Blue Cross California's decision to deny payment for the highest level of emergency department (ED) care in California.

Beginning in the second half of 2020 as hospitals and EDs in California and across the country were still grappling with uncertainty, fear, and overburdened staff during the pre-vaccine days of the COVID pandemic, Anthem began to deny payment to many small emergency physician groups in the state for care they provided to patients with some of the highest acuity conditions, such as heart problems, severe kidney infection with sepsis, and seizures, among others. These denials occurred throughout the state at different hospitals staffed by different emergency physician groups, regardless of whether they were in- or out-of-network with the health insurer.

As background, there are five levels of ED care, which are documented and billed for using CPT codes 99281 - 99285. These ED codes require all three key components (patient and family history, a physical examination, and the physician's medical decision-making) to be met and documented for the level of service billed in the emergency physician's claim. Patients are required to be categorized based on the severity of their presenting problem(s): for example, a Level 4 (99284) visit is a severe problem that requires urgent evaluation that will, without treatment, have a high chance of extreme impairment (however, does not pose an immediate threat to life or to physical function). A Level 5 (99285), on the other hand, is an immediate, significant threat to life or physiologic functioning. An additional point to be aware of is that emergency physician services are billed separately by the physician group from the facility fee, which is billed by the hospital.

It is care provided in these most severe cases that Anthem has refused to pay at all. Anthem has stated without sufficient evidence that the level of care billed is higher than the actual level of care provided. While it is not uncommon for health plans to review provider claims and determine whether they believe the claim should be adjusted based on bundling, downcoding, benefit limitations, and the like, it is unprecedented for a payer to stop payment to a physician group entirely because of a purported disagreement by the insurer over the code billed. Instead, insurers usually will pay emergency physicians what they unilaterally believe is appropriate, and our members can then decide whether to challenge that reimbursement through state law mechanisms or, if the insurance product in question is federally regulated, through the new independent dispute resolution process implemented under the *No Surprises Act*.

This is well-established practice because the law requires insurers to make a good faith effort for payment of a complete claim. To date, Anthem has refused to pay millions of dollars in claims that were correctly coded and billed. In fact, one of the emergency physician groups involved was able to compare their own records for such denied cases with those of the hospital's, and found that the hospital was paid at a Level 5—casting significant doubt on Anthem's assertion that the physician claims were fraudulently coded too high. The emergency care safety net will fail in the short term if insurers refuse to make payments as required by law. Physician groups have already indicated that lack of sufficient revenue makes it difficult to provide adequate staffing. Attracting and retaining the best emergency physicians to treat Californians is our top priority. The Anthem actions are particularly egregious as they appear to be targeted just at small emergency physician groups that staff only a single hospital—as small businesses, these groups are least able to absorb delays or denials of payment, nor do they have the staffing resources to continue to appeal this through the insurer's labyrinthine appeals processes.



Colorado West Healthcare System
2351 G Road
Grand Junction, CO 81505

Re: Inappropriate down coding of CPT evaluation and management (E/M) code

On the date of service listed above, the CPT E/M code for [a/an] [name of service] was reported with [CPT code]. [Health insurer] has inappropriately down coded the CPT E/M code submitted and changed the code to [new code], resulting in the inappropriate reduction of payment for delivered medical care. You adjusted the code, even though you are not a provider, coder and or without even having the benefit of the insured's medical records.

Community Hospital follows the American College of Emergency Physicians (ACEP) coding guidelines to assign the appropriate level of service.

The ACEP facility coding model provides industry standard methodology for assigning visit levels in an Emergency Department (ED). Determining the appropriate facility code/APC level is based solely on the "Possible Interventions". The **"Possible Interventions"** refer to interventions by the nursing and ancillary staff in the Emergency Department and not to interventions by the emergency physicians. **"Possible Interventions"** includes some procedure examples which might be billed separately.

Down coding of CPT E/M codes is not appropriate and in fact is unethical and illegal, without a thorough review of medical record documentation. The American Medical Association (AMA) strongly opposes automatic down coding and states:

The Ama guidance in part provides: "[t]he AMA vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers."

The appropriateness of the reported level of the CPT E/M [CPT code] is clearly documented within the patient's chart (attached). Based on the circumstances of this case, we are requesting that CPT E/M code [code] be paid in full and not be unethically and illegally down coded.

Please see the attached outlining the interventions performed that support the reported level of E&M [CPT Code] based on following [interventions].

Community Hospital now formally demands payment from (payor) in the amount of _____. If payment is not received within ____ days of the date of this letter, Community Hospital will pursue arbitration under the contract and further report this conduct to CMS or the Department of Insurance, as appropriate and permitted.

Community Hospital reserves all rights under contract, at law and in equity.
Thank you,

Peter J. Young, Esq
Chief Compliance Officer/Privacy Officer
(970) 644-3030

Medical Necessity and Inpatient Status

- Inpatient claims are high dollar claims, so big focus by carriers
- The inpatient only list – which one?
 - Medicare, Medicare Advantage, Commercial
 - The rules change
- Medical necessity
 - What is the standard?
 - MCG – Milliman's
 - InterQual
 - CMS Standard
- The value of claims warrant a fight

Carrier Address

Colorado West Healthcare System (CWHS)
2351 G Road
Grand Junction, CO 81505
NPI: 1497723407

Member Information

Re: Improper Denials and Demand for immediate payment.

Dear Sirs:

Colorado West Healthcare System dba Community Hospital provided medical services to your insured _____ on _____ through _____. Prior to providing treatment, on _____, Community Hospital requested from _____ the proper authorization for the inpatient medical services provided. The authorization permitted admission as an inpatient. Based on this authorization, Community Hospital provided medically necessary inpatient medical services. A clean and timely claim was submitted to _____ on _____.

Thereafter, Community Hospital received a denial from _____ stating that its own insured, _____ did not meet inpatient medical criteria. The denial is improper, inappropriate and contrary to well established and accepted guidelines and your own insurance policies.

The pertinent guidelines state in part:

Source and cite SIRS

Moreover, BCBS policies state that the above criteria is what governs inpatient status. *Cite*

Example Analysis:

This denial occurred despite the fact that the patient arrived via emergency department with a fever and a recent prostatectomy. An ultrasound revealed a right epididymitis which is to be treated with Rocephin. As stated in the medical records, *"the patient had a high probability of imminent life-threatening deterioration due to sepsis"*, which requires direct and immediate medical attention (Emphasis supplied). The patient met three of the four requirements for the SIRS criteria for inpatient admission. Similarly, the admission review supports the inpatient status. (See attached). Community Hospital has provided all requisite documentation to Anthem Blue Cross Blue Shield including an itemization of services, emergency medical records, progress notes, and all laboratory/radiology results.

The insured received medically necessary services at Community Hospital, which were authorized and approved. Despite this and having followed proper protocol for inpatient admission, you have failed to pay the claim. This is a violation of the written agreement between Community Hospital and _____ and is also bad faith claims handling, a violation of the insurance code.

Community Hospital now formally demands payment from Anthem Blue Cross Blue Shield in the amount of _____> If payment is not received within 30 days of the date of this letter, Community Hospital will pursue arbitration under the contract and further report this conduct to CMS or the Department of Insurance, as appropriate and permitted.

Community Hospital reserves all rights under contract, at law and in equity.

Thank you,

Peter J. Young, Esq.
(970) 644-3030

Questions and Answers

Pete Young

pyoung@gjhosp.org

Office - (970) 644-3030

Cell - (720) 755 1975