

Provider Reconsideration Form

This form is not to be used for member appeals or corrected claims submissions. Members, please contact member services at the number listed on your ID card.

Tips to avoid delays in processing your request

- Please submit only one form per claim.
- Attach appropriate supporting documentation (do not staple), such as applicable office notes/medical records/requesting provider's ordering summary and an explanation of why you believe a review is warranted.
- Complete all required fields. Information must be neatly typed and legible.

Please contact your Network Educator for claim issues involving 25 claims or more.

Member and Claim Information (all fields are required)

Member ID: _____

Member Name: _____

Date of Service: _____

Claim Number: _____

Provider Information (all fields are required)

National provider identifier (NPI): _____

Tax identification (EIN): _____

Provider name: _____

Telephone: _____

Provider contact name: _____

Review Reason: You must check one of the following:

Claims Review

<input type="checkbox"/>	Coordination of Benefits (COB)/Other Health Insurance (OHI)	Claim requires review due to potential coordination of benefits with another health insurance plan.
<input type="checkbox"/>	Payment Related (under/overpaid)	Inquiry related to units billed, manual pricing, contractual rates, fee schedule, authorization approved but not attached in processing, etc.
<input type="checkbox"/>	Invoices	Required when reimbursement for a Prosthetic Device Implant (PDI) is based on cost, as defined in contract. Submits invoice to support amount billed. This requirement may also apply to other cost-based reimbursement scenarios.
<input type="checkbox"/>	Itemized Bills	Claim requires an itemized bill showing detailed services and charges.
<input type="checkbox"/>	Timely Filing	Claim was submitted outside the required timeframe. Please include an explanation for the untimely filing along with supporting documentation (i.e. EOB from another carrier). Please note that the EOB must show proof of a timely submission to previous carrier for consideration.
<input type="checkbox"/>	Medicare Non-participating	Reconsideration request for a claim involving a non-participating provider for a Medicare member.
<input type="checkbox"/>	Other Denial Reason:	Explanation:
<input type="checkbox"/>	Other Review Reason:	Explanation:

Coding

<input type="checkbox"/>	Coding Guidelines (CPT Bundling/Unbundling) – Please include explanation/justification for additional reimbursement
<input type="checkbox"/>	Medical records/Operative Report

Clinical

<input type="checkbox"/>	Authorization was Denied (Requesting retro-authorization review)
<input type="checkbox"/>	Authorization was not obtained (Claim was denied due to no authorization on file)
<input type="checkbox"/>	Denied – Medical Necessity Not Established