Provider Claim Reconsideration Procedure



If a claim is not processed as expected, providers should follow the reconsideration process outlined below. This process is distinct from appealing an adverse benefit determination (before a claim is submitted). Reconsideration focuses on how the claim was processed, without modifying the original claim.

1. **Reconsideration Definition:** At Sentara Health Plans, a claim payment reconsideration is a provider's request to review the original processing of a claim. It does not involve changes to the claim itself but assesses whether the initial decision was accurate.

2. Filing Deadline

- First-Level Reconsideration: Must be submitted within 365 days from the last date of service.
- Second-Level Reconsideration: Must be submitted within 60 days of the first-level claim reconsideration determination.
- Medicare Non-Contracted Providers:
 - Must submit a reconsideration within 60 days of the claim denial date.
 - A signed Waiver of Liability Form is required. By signing, you agree to not bill the member for denied services
 - Note: Medicare non-contracted providers are only eligible for one level of reconsideration.
- Sentara Health Plans Response Time: You will receive a response within 60 days of receipt of reconsideration.

3. Required Forms

Use the appropriate form based on the type of claim submitted. All forms are available on our website.

- o Provider Reconsideration Form for medical claims
- o Behavioral Health Provider Reconsideration Form for behavioral health claims
- Waiver of Liability Form for Medicare Non-Contracted Providers

4. Submission Instructions

To submit a reconsideration:

- 1. Complete the appropriate <u>Provider Reconsideration Form</u>.
- 2. Attach any supporting documentation.
- 3. Instructions for submission are located at the top of the Provider Reconsideration Form.

5. Additional Considerations

o **Incomplete Submissions:** Missing or incomplete information may result in the original decision being upheld.