

# 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.
  - **Medicare Non-Contracted Providers:**
    - Must submit a reconsideration within **65 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.
  - **Second-Level Reconsideration:** Must be submitted within **65 days** of the first-level claim reconsideration determination.
  - **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.

- **Provider Reconsideration Form** – for medical and behavioral health claims
- **Waiver of Liability Form** – for Medicare Non-Contracted Providers

### 4. Submission Instructions

To submit a reconsideration:

1. Complete the [Provider Reconsideration Form](#).
2. Attach any supporting documentation.
3. Instructions for submission are located on the Provider Reconsideration Form.

### 5. Additional Considerations

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