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 **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.*
   - **Second-Level Reconsideration:** Must be submitted within **60 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.