Provider Request for Claim Review

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

Fax Request to: (800) 452-3847 **Mail to: AvMed, PO Box 569004, Miami, FL 33256**

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 Representative 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: _____
Provider Contact Name: _____ Telephone: _____

Review Reason: You Must Check One of the Following:

Claims Review		
☐	Coordination of Benefits (COB)/Other Health Insurance (OHI)	Claim requires review due to potential coordination of benefits with another health insurance plan.
☐	Payment Related (under/overpaid)	Inquiry related to units billed, manual pricing, contractual rates, fee schedule, authorization approved but not attached in processing, etc.
☐	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.
☐	Itemized Bills	Claim requires an itemized bill showing detailed services and charges.
☐	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.
☐	Medicare Non-participating	Reconsideration request for a claim involving a non-participating provider for a Medicare member.
☐	Other Denial Reason:	Explanation:
☐	Other Review Reason:	Explanation:
Coding		
☐	Coding Guidelines (CPT Bundling/Unbundling) – Please include explanation/justification for additional reimbursement	
☐	Medical records/Operative Report	
Clinical		
☐	Authorization was Denied (Requesting retro-authorization review)	
☐	Authorization was not obtained (Claim was denied due to no authorization on file.)	
☐	Denied – Medical Necessity Not Established	