



Good Afternoon
Thank you for waiting while we gather.

NOTE: Using Otter.ai or similar artificial intelligence notetaking platforms violates Sentara Health Plans' (SHP) meeting recording policy. Please do not use any such platforms while attending SHP webinars. We appreciate your cooperation.



Welcome to Navigating the Appeals, Reconsiderations & Contestment Processes

2nd Quarter 2026

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Agenda



1. Appeals process
2. Reconsideration process
3. Contestment process
4. Locate forms and related resources online
5. When and how to follow up
6. Q & A

What is an Appeal?

A formal request to reconsider and change a previous adverse decision on a prior authorization request.

The Appeals process applies before a claim is submitted for payment. Once a claim is processed, a provider should follow the Provider Reconsideration Process.

Appeals Process Steps

1. Authorization Denied

- ☐ Occurs before a claim is submitted for payment

2. Submit Appeal Request

- ☐ Member or appointed representative (includes provider) submit pre- service appeal within appropriate timeframe and using acceptable methods based on the line of business
- ☐ Indicate “Expedited Appeal” on form when criteria are met

3. Case Review

- ☐ All necessary documentation must be available

4. Decision

- ☐ Standard OR Expedited within **three** days

5. Written Notice

- ☐ Member and authorized representative (includes provider) by letter Standard and Expedited
- ☐ Process complete



Fax forms to the number listed on the appeal form only. Forms sent to the reconsideration or other team must be redirected and may cause decision delays.

Appeals Submission Methods and Timelines Vary

Commercial

- File within **180** days of denial
- Submit to the fax #, mail address or email **listed on the form**
- Decision timelines:
 - Standard appeals resolve within **30** calendar days of receipt
 - Expedited appeals resolve within **72** hours of receipt
 - Cancer related pain medication resolve within **24** hours

Medicare

- Within **65** days from the date on the Adverse Benefit Letter
- Submit by fax, mail, hand delivery, email, call Medicare member services, call Medicare Appeals and Grievances department
- Decision timelines:
 - Standard appeals resolve within **30** calendar days
 - Part B appeals resolve within **7** business days
 - Expedited resolve within **72** hours

Medicaid

- File within **60** days from the date on the Adverse Benefit Letter (member's consent required)
- Submit by fax, mail, hand delivery, email, call Medicaid member services
 - Acknowledgment within **5** calendar days of submission for standard appeals
- Decision timelines:
 - Standard appeals resolve within **30** calendar days
 - Expedited appeals resolve within **72** hours

View procedure for details about FAMIS and State Fair Hearing and External Reviews

What is a Reconsideration?

A reconsideration is distinct from a claim correction and distinct from an appeal of an Adverse Benefit Determination. A reconsideration is a written request submitted by the provider seeking a review of how a claim was adjudicated. It is important to note that a reconsideration **does not involve** any changes to the **original claim**.

NOTE: Applies to an original, unmodified claim.

Reconsideration Process Steps

1. Claim Does Not Process As Expected

- ☐ Applies to original, unmodified claim

2. Identify Correct Form

- ☐ [Provider Reconsideration Form](#) – medical and behavioral health claims
- ☐ [Waiver of Liability Statement](#) – Medicare non-contracted providers (cannot bill member for denied services)

3. Submit

- ☐ **Follow submission instructions on the top of the form**
 - Within **365** days of last DOS (not applicable to Medicare non-contracted providers)
 - Within **65** days
 - Claim denial date
 - Medicare non-contracted providers
- ☐ Missing or incomplete information may result in the original decision being upheld

4. Response

- ☐ Within **60** days

Submission of Reconsiderations

If a claim is not processed as expected, providers should follow the reconsideration process outlined in the Provider Claim Reconsideration Procedure on the website; [Appeals & Reconsiderations | Providers | Sentara Health Plans](#). 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.

Submission Instructions

To submit a reconsideration:

- Complete the **Provider Reconsideration Form**
- Attach any supporting documentation
- Instructions for submission are located on the **Provider Reconsideration Form**.

Additional Considerations

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

Provider Reconsideration Form

A [Provider Reconsideration Form](#) is required for medical and behavioral health claims. One form is to be submitted for each claim being reconsidered. Missing or incomplete information may result in the original decision being upheld.

It is important to fill out the form in its entirety with accurate documentation on the form which begins with completion of the top of the form.

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:	

What is a Corrected Claim?

A ‘re-billed” or “corrected claim” is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures.

Corrected Claim Submission of a Previously Billed UB-04 Claims

- ☐ Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- ☐ The first digit of the bill type indicates the type of facility.
- ☐ The second digit indicates the type of care provided.
- ☐ The third digit indicates the frequency of the bill.
- ☐ Billing type is important for interim billing or a replacement/resubmission bill.
- ☐ “Resubmission” should be indicated in block 80 or any other unoccupied block of the UB-04.

[Provider Manuals and Directories](#) | [Providers](#) | [Sentara Health Plans](#)



The image shows a UB-04 claim form. Two red circles highlight specific areas:

- Top Right Circle:** Highlights the 'TYPE OF BILL' field in block 4, which is currently blank.
- Bottom Circle:** Highlights the 'REMARKS' field in block 80, which is currently blank.

The form includes various sections for patient information, dates, codes, and charges. The bottom of the form includes the text 'UB-04 CMS-1450' and 'APPROVED OMB NO. 0938-0997'.

Corrected Claim Submission of a Previously Billed CMS-1500 Claims

- ❑ Claims submitted for correction require a “7” in box 22.
- ❑ Claims that need to be voided require an “8” in box 22.
- ❑ Enter the original claim number of the claim you are replacing in the right side of item 22.

[Provider Manuals and Directories](#) | [Providers](#) | [Sentara Health Plans](#)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/02

22. RESUBMISSION CODE (Box 22, circled in red)

ORIGINAL REF NO (Box 22, circled in red)

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER (Box 25)

26. PATIENT'S ACCOUNT NO. (Box 26)

27. ACCEPT ASSIGNMENT? (Box 27)

28. TOTAL CHARGE (Box 28)

29. AMOUNT PAID (Box 29)

30. BILLING PROVIDER INFO & PH # (Box 30)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Box 31)

32. SERVICE FACILITY LOCATION INFORMATION (Box 32)

33. BILLING PROVIDER INFO & PH # (Box 33)

PLEASE PRINT OR TYPE

APPROVED CMB-0935 11/97 FORM 1500 (02-12)

What is a Contestment?

An industry term that refers to a dispute with supporting evidence that the health plan's claim recovery effort is erroneous.

Must occur prior to claim adjustment.

Sample Recovery Letter

June 12, 2025

Notice of Overpayment

Dear Provider,

This letter is to notify you that Sentara Health Plans has made an overpayment to you in the amount of \$385.00.

The overpayment was identified as a result of: Member was covered under an additional insurer during the service date.

Please see the attached claim report from Sentara Health Plans. These overpayments will be offset through the claims retraction process.

You have the right to contest this claim for overpayment. To do so:

- Submit your response within 35 days from the date of this letter
- Send your documentation to: contestments@sentara.com
(This is a secure electronic option for the most efficient review)
- Include the following in your submission:
 - Subject of email should be:
IR-0576956 COUNTY OF HENRICO VIRGINIA
 - Specific Claim Information
 - A clear explanation of why you are contesting the overpayment

To issue a refund check instead of contesting:

- Make the check payable to Sentara Health Plans and include:
 - A copy of this letter and the attached claim report
- Mail the check and documentation to:

**Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466**

If no refund check is received in 35 days, Sentara Health Plans will offset the related claims through the retraction process. We may offset negative balances against other Sentara Health Plans product lines.

If you have any questions on this process, please contact our provider customer service department at 1-800-229-8822. Thank you in advance for your cooperation.

Sincerely,
Sentara Health Plans

Attachment: IR-0576956

PROV_1218-MRL-400068

Contestment Process Steps

1. Recover Letter Received

- ☐ Providers will have **35** days to Contest
- ☐ Please read the recovery letter in FULL it will outline the necessary procedures to contest.

2. Initiate Contestment

- ☐ Send an email to contestments@sentara.com
- ☐ If the recovery window has expired the provider may submit a claims reconsideration after the claim has been adjusted. **NOTE: A reconsideration cannot be submitted until AFTER the money has been retracted.**

3. Review

- ☐ Contestments under review will not be adjusted during that window.

4. Decision

- ☐ Within **35** days

5. Written Notification

- ☐ Response providing direction on follow-up and required details will be sent via email

Locate Resources on Sentarahealthplans.com/providers

Overview of Appeals, Reconsiderations & Contestment Processes

[Overview of the Appeal, Reconsideration, and Contestment Processes](#)

Provider Claim Reconsideration Procedure

[Sentara Health Plans Provider Claim Reconsideration Procedure](#)

Provider Claim Reconsideration Form

[Provider Reconsideration Form](#)

Avoiding Common Claims Submission Errors

[Sentara Health Plans Avoiding Common Claim Submission Errors](#)

When and How to Follow Up

Appeals: If a decision has not been communicated within the promised timeframe, contact the appeals team using the email or phone number listed on the form.

Reconsiderations: If a decision has not been communicated within the stated timeframe, please contact provider customer service at **1-800-229-8822**.

Contestments: Providers will have **35** days to Contest. To initiate a request, send an email to contestments@sentara.com

Provider Webinars | Sentara Health Plans

New Provider Orientation

Aoril 9, 2026 8-9 AM

April 15, 2026 7-8 AM

Comprehensive introduction to our health plans, designed both for newly contracted providers and those seeking a refresher. This session delivers an in-depth overview of our key resources, self-service tools, and core operational processes to support an efficient and successful working relationship.

Let's Talk Behavioral Health

May 11, 2026 1-2 PM

Comprehensive session developed to keep professionals informed, prepared, and ready for what's next. This will equip you with the knowledge and tools to make informed decisions and successfully partner with us.

Appeals, Reconsiderations, and Contestment Processes

July 8, 2026 1-1:30 PM

October 7, 2026 1-1:30 PM

Training session designed to help you navigate submission of appeals, reconsiderations and contestments. Distinguishing the differences in the submission processes and requirements by plan type, introduce the procedures and other related self-help resources available on the provider website

Lunch & Learn: Provider Website Tour

(New Provider Orientation Part 2 & Refresher)

April 23, 2026 12-13:30 PM

Take a break and join us for an informal, yet informative, session designed to make navigating our provider website simple and efficient. During this hour, you'll discover how to, Navigate our provider portal with confidence, Access, utilize self-help resources, Find guidance and tools to successfully conduct business with us. Bring your questions and curiosity! We're here to help you get the most out of our resources!

Provider Quality Care Learning Collaborative

May 6, 2026 12-1 PM

June 3, 2026 12-1 PM

We focus on a specific topic each month, highlight any significant changes, review relevant quality or value-based care measures, address areas of opportunity we are focused on, review member support resources, programs and initiatives, and share provider resources to support your care gap closure efforts. We encourage your designated quality subject matter expert(s), key clinical representative(s), and other staff members to join us virtually to learn how you can identify and address care gaps effectively.

