



CLAIMS RECONSIDERATION REQUEST FORM

As a participating provider, you may request a claim reconsideration of any claim submission that you believe was not processed according to medical policy or in keeping with the level of care rendered. Requests for reconsideration must be submitted in writing. Kindly comply with the following:

1. Complete a **Claims Reconsideration Request Form** (*attached*) and provide any applicable details below.
2. Attach any information (*Medical records, Operative reports, or other documentation*) necessary to support your request to your completed **Claims Reconsideration Request Form**.
3. All claim reconsiderations must be submitted no later than sixty (60) calendar days from the receipt of the original EOB.
4. Provider will be sent an EOB or determination letter indicating the outcome of the reconsideration request.
5. Claim reconsideration requests can be faxed to (516) 394-5693 or mailed to:

**HealthCare Partners, MSO
Attn: Claims Reconsiderations
501 Franklin Avenue Suite 300
Garden City, NY 11530**

Details:



CLAIMS RECONSIDERATION REQUEST FORM

Claim Information

Member's Name:	Member's ID:
Claim Number:	Date of Service:
Provider's Name:	Provider's ID:

Requestor Information (if not Provider)

Agency:	
Address:	
Contact Person:	Phone Number:

Claim Reconsideration Reason – Please select the reason most applicable

- Denied for no referral/authorization – **Authorization attached.**
- Denied for no referral/authorization – **Disputing need – Explanation attached.**
- Denied for no referral/authorization – **Service(s) urgent/emergent – Medical records attached.**
- Denied for untimely filing – **Proof of timely filing attached.** (*Acceptable proof of timely filing: EOB, EDI, NEIC, Computer Generated Ledger, Copy of a dated computer generated HCFA 1500, or a copy of a claim submitted via certified return mail receipt.*)
- Denied incorrectly as Member not eligible on date of service.
- Denied for additional information – **Requested records w/evidence of original submission date attached.**
- Questioning copayment – **Explanation attached.**
- Claim paid/down-coded service – **Detailed explanation w/records to support service level attached.**
- Denied for bundling – **Detailed explanation w/supporting medical records attached.**
- Claim denied pending primary EOB – **EOB attached from primary carrier attached.**
- Claim not paid at correct fee schedule – **Contract rate page/detailed explanation attached.**
- Claim processed as capitated service(s) – **Service(s) excluded from capitation.**
- Resubmission of corrected claim.
- Reporting overpayment – **Explanation attached.**
- Reporting no payment/no EOB or wrong vendor paid – **Explanation attached.**
- Facility DRG question – **Explanation attached.**
- General question(s)/Dispute (*i.e. Coding, Modifier, Quantity, etc.*) – **Detailed explanation attached.**

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