Request for Claim Review Form

COMPLETE ALL INFORMATION REQUIRED ON THE "REQUEST FOR CLAIM REVIEW FORM".
INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

Today's Date (MM/DD/YY):		**Health Plan Name:**	

Denotes required field(s)

Provider Information

***Provider Name:**		***Contact Name:**	
***National Provider Identifier (NPI):**		***Contact Phone Number:**	
Contact Fax Number:		**Contact E-mail Address:**	
***Contact Address:**			

Member / Claim Information

***Member ID:**		***Member Name:**		
***Date(s)of Service (MM/DD/YY):**				
***Claim Number:**		***Denial Code:**		

*Review Type

Enter X in one box, and/or provide comment below, to reflect purpose of review submission.

☐	**Contract term(s):** The provider believes the previously processed claim was not paid in accordance with negotiated terms.
☐	**Coordination of Benefits:** The requested review is for a claim that could not fully be processed until information from another insurer has been received.
☐	**Corrected Claim:** The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made:
☐	**Duplicate Claim:** The original reason for denial was due to a duplicate claim submission.
☐	**Filing Limit:** The claim whose original reason for denial was untimely filing.
☐	**Payer Policy, Clinical:** The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
☐	**Payer Policy, Payment:** The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
☐	**Pre-Certification/Notification or Prior-Authorization or Reduced Payment:** The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
☐	**Referral Denial:** The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
☐	**Request for additional information:** The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC Codes, Home Infusion Therapy).
☐	**Retraction of Payment:** The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).
☐	**Other:**

Comments *(Please print clearly below)*:

Attach all supporting documentation to the completed "Request for Claim Review Form".