Friday FAX

The week of ______________(date)

CoventryCares of Kentucky Medicaid Reconsideration Form

When filing reconsideration on a claim denial for your CoventryCares of Kentucky Medicaid claims, please use the attached form. For CoventryCares of Kentucky Medicaid, the address to submit to is different, so please use this form. For our Medicaid Plan, all correspondence must be sent to:

CoventryCares of Kentucky
Attn: Kentucky Reconsideration Team
P.O. Box 7812
London, Kentucky 40742

This form can be found on our website and directprovider.com, the addresses are listed below.

As always, do not hesitate to contact your Provider Relations Representative with any questions or concerns:

Mark Leonard	**(502) 794-1434**	**mxleonard1@cvty.com**
Melissa Powell	**(270) 779-8943**	**mnpowell@cvty.com**
Kristy Cabell	**(502) 689-4894**	**kdcabell@cvty.com**
Jon Gillispie	**(502) 689-3748**	**jdgillespie@cvty.com**
Christy Vowels	**(502) 794-0864**	**clvowels@cvty.com**
Donna Moor	**(502) 689-3629**	**dmmoor@cvty.com**
Krista Hubbard	**(502) 689-4515**	**kxhubbard@cvty.com**
Barbara Jones	**(502) 438-7963**	**bljones1@cvty.com**

CoventryCares of Kentucky
Provider Relations Department
9900 Corporate Campus Dr, Ste1000.
Louisville, KY 40223
Provider Relations Fax: (855) 454-5584
Customer Service: (855) 300-5528

www.CoventryCaresKY.com www.directprovider.com

If you would like the weekly fax blast emailed to you rather then faxed, please notify your Provider Relations Representative above.

CLAIM CORRECTION / RECONSIDERATION FORM

MAIL TO:
CoventryCares of Kentucky
Attn: Kentucky Reconsideration Team
PO Box 781
London, Kentucky 40742
Telephone#

FROM:

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☐ **Corrected Claim** ☐ **Proof of Timely Filing** ☐ **Requested Information** ☐ **Request for Reconsideration**

Member Name: ____________________________ **Member ID Number:** __________________

Date(s) of Service: ____________________________ **Remittance Advice Date:** __________________

Amount Billed: ____________________________ **Amount Paid:** __________________

Claim Number(s): ____

This form is to be used ONLY for:

- Submission of a standard claim correction
- Proof of timely filing for an **initial** untimely filing denial
- Response to CoventryCares Kentucky regarding requests for additional information (i.e. ER notes, operative reports, primary carrier Explanation of Benefit/Remittance Advice, etc.)
- Submission of medical records **along** with a summary of why authorization was not obtained for services denied for no authorization

Please use the space below to supply any other necessary information, along with your attachment(s), to enable thorough reconsideration:

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____ ____
Signature of Sender Date