CLAIMS RECONSIDERATION FORM

***This is an electronically fillable form**

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- Corrected claims should be submitted to the claim address on the back of the Member's Community Health Options identification (ID) card: Community Health Options, Mail Stop 200, P.O. Box 1121, Lewiston, ME, 04243. If the claim in question has no payments to date or you are submitting additional information for the initial review of payment, please forward to the address on the back of the Member's ID card. Corrected claims can be submitted electronically. Community Health Options' Emdeon payor ID number is 45341.
- Corrected claims submitted on a CMS 1500: please include frequency code 7.
- Corrected claims submitted on a UB-04: please include 7 as the third digit of the bill type.
- Fee schedule or reimbursement items for multiple Members do not require individual reconsiderations. Contact Community Health Options Member Services Department at 855-624-6463 for further assistance. If you are a contracted health care professional and you feel your contract is being inappropriately applied, please contact your Provider Relations Department at Community Health Options.

Step 1: Contact Community Health Options' Member Services Department at 855-624-6463 to review any adverse determinations/payment reduction related reconsideration requests. If a Member Service Associate is unable to change the initial decision, you will be advised at that time of your right to request a reconsideration.

Step 2: Complete and email or mail this form along with all supporting documentation to the address identified in Step 3 on this form. Your reconsideration should be submitted within 180 days of the date of EOP for any claim requesting review. Please allow 60 days for Community Health Options to process your reconsideration, unless other timelines are required by state law.

REQUESTS FOR REVIEW SHOULD INCLUDE:

1. This completed form requesting a reconsideration review and indicating the reason(s) why you believe the claim payment is incorrect and should be modified.
2. Include a copy of the original claim and the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable.
3. For reviews involving a previous clinical denial, such as denied hospital days, level of care, medical necessity or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable.

No new claims should be submitted with this form. Please submit a separate form for each claim.

MEMBER INFORMATION

Member ID:		Community Health Options Claim #	
Date of Service:	Billed Amount:	Allowed Amount:	
Member Name – Last:		First:	MI:
Member Date of Birth (DOB):		State:	Zip:
Patient Name: Last		First:	MI:

PHYSICIAN / HEALTH CARE PROFESSIONAL INFORMATION

Tax Identification Number (TIN):	Phone Number:	Email Address:	
Physician Name (as listed on Explanation of Payment (EOP)) / Explanation of Benefits EOB:			
Last:		First:	Provider NPI:
Practice Service Address:		State:	Zip:
Facility / Group Name:		Contact Person:	
Amount Owed (Optional):			

REASON FOR REQUEST:

Please check the issue that best describes your reconsideration. The initial decision was related to:

- ☐ Mutually exclusive, incidental, bundling, or duplicative procedure code denial
- ☐ Contract and/or fee schedule or reimbursement terms
- ☐ Modifier reimbursement: List modifier(s): _____
- ☐ Inpatient facility denial (level of care, length of stay, delayed treatment day)
- ☐ Experimental / Investigational procedure
- ☐ Medical necessity of the service
- ☐ Timely claim filing (please include proof of original submission, if applicable)
- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Maximum reimbursable amount
- ☐ Other (please indicate): _____

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State the reason for the reconsideration and expected outcome below. Please attach supporting documentation.

Name of Requestor:	Title of Requestor:
Phone #:	Email Address:
Signature:	Today's Date:

☐ **Check if additional information is attached**

Step 3: Mail this completed form (Request for Health Care Professional Review) **along with all supporting documentation** to the address noted below:

Forms must be mailed-in or scanned and sent via e-mail to: Provider@HealthOptions.org. Faxed copies **WILL NOT** be acceptable.

COMMUNITY HEALTH OPTIONS
ATTN: PROVIDER RELATIONS
MAIL STOP 400
P.O. BOX 1121
LEWISTON, ME 04243