1199SEIU Benefit Funds

Medical Claims Reconsideration, PO Box 717, New York, NY 10108-0717

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MEDICAL CLAIM RECONSIDERATION REQUEST

COMPLETE A SEPARATE FORM FOR EACH CLAIM • PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Date: _____

Patient name: _____ Health ID #: _____

Claim number: _____ Original claim: ☐ Paper ☐ Electronic

Diagnosis code: _____

Rendering provider name: _____

Facility/Group name: _____

Provider Tax ID #: _____ Provider NPI #: _____

Amount billed: _____ Amount paid: _____

Date(s) of service: _____ Date paid: _____

REASON FOR RECONSIDERATION: Indicate the reason(s) why you are filing this request (check all that apply):

❑ 1. Claim was previously denied as "Exceeds Timely Filing" ***(Attach proof of timely filing)***

❑ 2. Claim was previously denied with request for clarification/additional information ***(Attach requested documents)***

❑ 3. Claim was previously denied due to a lack of information regarding "Coordination of Benefits" information ***(Attach primary carrier's EOB)***

❑ 4. Claim was previously denied due to submission of incorrect information ***(Explain correction below)***

❑ 5. Claim was previously denied due to a dispute of the applied contracted rate ***(Explain below)***

❑ 6. Claim was previously denied with request for revisions that follow Correct Coding Initiative (CCI) guidelines for bundled claims ***(Attach revised coding and explain below)***

❑ 7. Claim was previously denied for lack of authorization/medical necessity ***(Attach proof of authorization/clinical documentation)***

❑ 8. Claim was previously denied because an incorrect Tax Identification Number (TIN) was provided

❑ 9. Claim was previously denied because member was deemed ineligible for services provided, but member is eligible

❑ 10. Other ***(Explain here):*** _____

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Reconsideration request must be submitted within 180 days of the date the claim was originally denied or paid.