COMMUNITY Health Options®

Claim Reconsideration Form

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- This form is only used for requesting reconsideration of a payment decision on a previously processed claim. Corrected (replacement) claims, void requests, and late or interim charges must follow regular submission processes.
- Replacement (corrected) claims may be submitted electronically to Health Options payer ID 45341, or to the claim address on the back of the Member's identification (ID) card: Community Health Options, Mail Stop 200, P.O. Box 1121, Lewiston, ME, 04243.
- Please refer to Health Options Replacement Claims Policy for complete submission guidelines.

Step 1: Contact Member Services Department at 855-624-6463 to review any adverse determinations/payment reduction related reconsideration requests. If a 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 must be submitted within 90 calendar days from the date of the Explanation of Payment for any claim reconsideration request. Please allow up to 60 calendar 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 including the reason(s) why you believe the claim payment is incorrect and should be modified.
2. A copy of the original claim and the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable.
3. Supporting documentation for any benefit denials (i.e. reason for untimely notification or no prior authorization obtained) or medical necessitydenial (i.e. Additional medical records), as applicable.

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

MEMBER INFORMATION			
Member ID:		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):			

Please select 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 modifiers:_____
- ☐ Timely claim filing (please include proof of original submission, if applicable)
- ☐ Timely notification of service request
- ☐ Failure to obtain prior approval authorization
- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Maximum reimbursable amount
- ☐ Other (please indicate):_____

COMMUNITY Health Options™

Claim Reconsideration Form

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

_____

_____

Name of Requestor: _____ Title of Requestor: _____

Phone #: _____ Email Address: _____

Return Address (for notices regarding this request): _____

_____

Signature:_____ Today's Date: _____

Step 3: Mail, or scan and e-mail this completed form along with all supporting documentation to:

E-mail: reconsiderations@HealthOptions.org

Mail: MAIL STOP 800
RECONSIDERATIONS AND APPEALS
COMMUNITY HEALTH OPTIONS
P.O. BOX 1121
LEWISTON, ME 04243