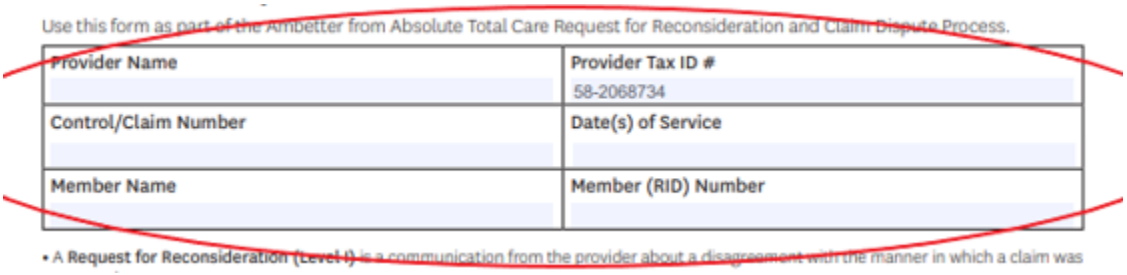
How to Fill Out A Reconsideration and Claim Dispute Form for Ambetter of North Carolina

Use this form as part of the Ambetter from Absolute Total Care Request for Reconsideration and Claim Dispute process. *Please complete the form properly and entirely for the appeal to be considered.*

1. You will need to fill out the entire top section of the form.

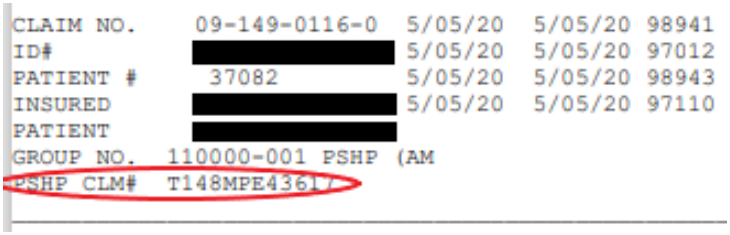


Use this form as part of the Ambetter from Absolute Total Care Request for Reconsideration and Claim Dispute Process.

Provider Name	Provider Tax ID #
	58-2068734
Control/Claim Number	Date(s) of Service
Member Name	Member (RID) Number

• A Request for Reconsideration (Level I) is a communication from the provider about a disagreement with the manner in which a claim was

   a. Under 'Provider Name', input the doctor's first and last name (under which they are credentialed with ActivHealthCare).
   b. Under 'Provider Tax ID #', use the ActivHealthCare TIN is there (58-2068734).
   c. Under 'Control/Claim Number', you will want to use Ambetter's claim number, which is listed on the remittance advice as 'PSHP CLM#'. (see example below)



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CLAIM NO.     09-149-0116-0  5/05/20  5/05/20 98941
ID#           [redacted]     5/05/20  5/05/20 97012
PATIENT #      37082         5/05/20  5/05/20 98943
INSURED       [redacted]     5/05/20  5/05/20 97110
PATIENT       [redacted]
GROUP NO.   110000-001 PSHP (AM
PSHP CLM#   T148MPE43617
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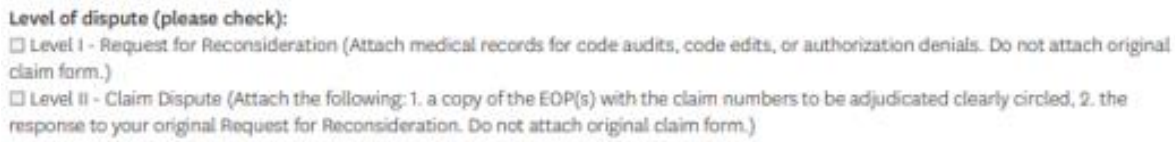
d. Under ‘Date(s) of Service’, input the patient’s date of service that you are appealing.

   **If it’s a date range, write out the complete date (i.e. 10/1/2024-10/4/2024)

e. Under ‘Member Name’, input the patient’s name for which you are appealing. Be sure to use the name listed on the patient’s insurance card.

f. Under ‘Member (RID) Number’, input the patient’s ID number found on the patient’s insurance ID card. Please include any leading letters and any suffixes. (i.e. U9123456701)

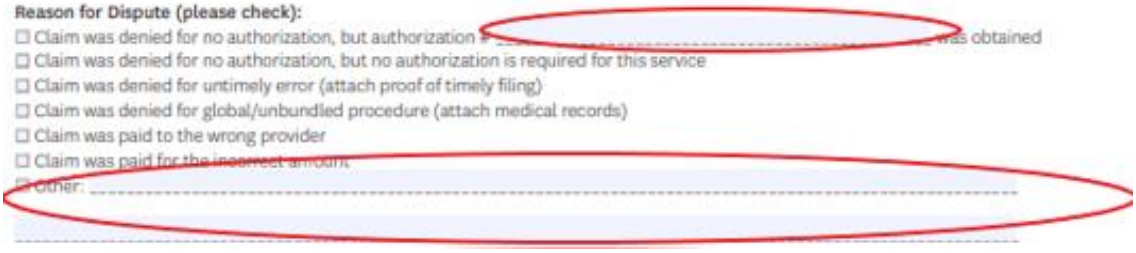
2. Read the directions on the form itself to ensure you need to appeal and what level of appeal you need. Then under ‘Level of dispute’, select which one you are seeking.


Level of dispute (please check):
☐ Level I - Request for Reconsideration (Attach medical records for code audits, code edits, or authorization denials. Do not attach original claim form.)
☐ Level II - Claim Dispute (Attach the following: 1. a copy of the EOP(s) with the claim numbers to be adjudicated clearly circled, 2. the response to your original Request for Reconsideration. Do not attach original claim form.)

   a. *Request for Reconsideration (Level I)* is a communication from the provider about a disagreement with the way a claim was processed.

   b. *Claim Dispute (Level II)* should be used only when a provider has received an unsatisfactory response to a Request for Reconsideration.

3. Under ‘Reason for Dispute’, select the option that best fits your request.



Regardless of the reason for your dispute, you **must** explain in detail why you are appealing. If multiple reasons or multiple codes, provide details.

For Example: CPT code 98943 should be processed as separate procedure.

4. Fill out the last section accordingly.

   a. Under ‘Requestor Name’, input the first and last name of the person requesting (this can be the provider, CA, office manager, etc.).
   b. Under ‘Requestor Phone Number’, use your best contact phone number.
   c. Under ‘Date of Request’, input today’s date.

5. When the form has been completely filled out, address the envelope to the address listed on the form.

Ambetter
Attn: Claim Dispute
P.O. Box 5000
Farmington, MO 63640-5000

6. You must send S.O.A.P. notes to appeal a denial. Do not send CMS1500 form.

Things to keep in mind:

- All requests **must be received within 180 days** from the date of the original date Ambetter processed the claim.
- Please allow 30 business days for your appeal to be processed.
- If you are submitting a 'Corrected Claim', you do NOT need to fill out this form.

ambetter. FROM absolute total care

PROVIDER REQUEST FOR RECONSIDERATION AND CLAIM DISPUTE FORM

Use this form as part of the Ambetter from Absolute Total Care Request for Reconsideration and Claim Dispute Process.

Provider Name	Provider Tax ID #
	58-2068734
Control/Claim Number	**Date(s) of Service**
Member Name	**Member (RID) Number**

- A **Request for Reconsideration (Level I)** is a communication from the provider about a disagreement with the manner in which a claim was processed.
- A **Claim Dispute/Claim Appeal (Level II)** should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.
- A Claim Dispute/Claim Appeal must be submitted on this claim dispute/appeal form, which can also be found on our website. The claim dispute form must be completed in its entirety. The completed claim dispute/appeal form may be mailed to:

Ambetter
Attn: Claim Dispute
P.O. Box 5000
Farmington, MO 63640-5000

- A Claim Dispute/Claim Appeal will be resolved within 30 calendar days. A provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

Level of dispute (please check):

☐ Level I - Request for Reconsideration (Attach medical records for code audits, code edits, or authorization denials. Do not attach original claim form.)
☐ Level II - Claim Dispute (Attach the following: 1. a copy of the EOP(s) with the claim numbers to be adjudicated clearly circled, 2. the response to your original Request for Reconsideration. Do not attach original claim form.)

Reason for Dispute (please check):

☐ Claim was denied for no authorization, but authorization # _____ was obtained
☐ Claim was denied for no authorization, but no authorization is required for this service
☐ Claim was denied for untimely error (attach proof of timely filing)
☐ Claim was denied for global/unbundled procedure (attach medical records)
☐ Claim was paid to the wrong provider
☐ Claim was paid for the incorrect amount
☐ Other: _____

_____

Requestor Name: _____

Requestor Phone Number: _____ **Date of Request:** _____

Mail completed form(s) and attachments to the appropriate address:
Ambetter, Attn: Claim Dispute, P.O. Box 5000, Farmington, MO 63640-5000

All requests for corrected claims, reconsiderations, or claim disputes must be received within 60 days from the date of the original explanation of payment or denial.

AMB20-SC-P-05042020-1