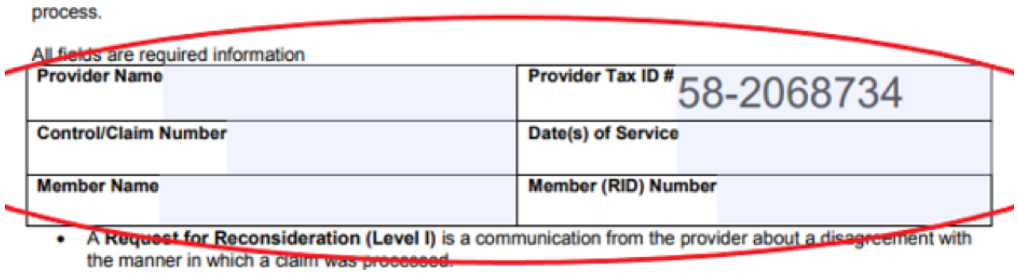
How To Fill Out A Reconsideration and Claim Dispute Form For Peach State Health Plan Ambetter

Use this form as part of the Ambetter from Peach State Health Plan Request for Reconsideration and Claim Dispute process. *The form must be filled out properly and entirely for the appeal to be considered.*

1 Fill out the entire top section of the form.



process.

All fields are required information

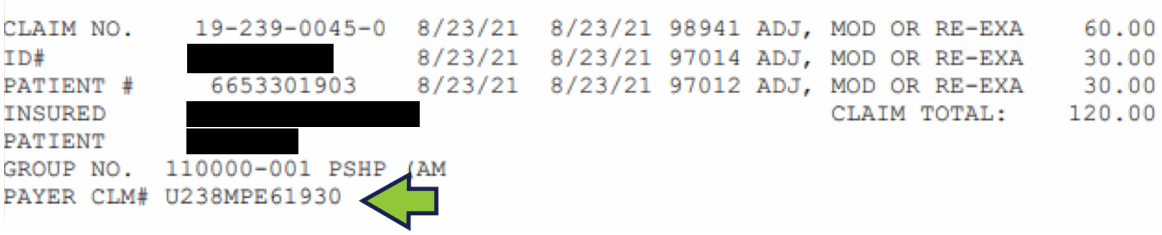
Provider Name	Provider Tax ID # 58-2068734
Control/Claim Number	Date(s) of Service
Member Name	Member (RID) Number

- 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. Under "Provider Name", put the doctor's first and last name. (The name they are credentialed under with ActivHealthCare.

b. Under "Provider Tax ID #", use the ActivHealthCare TIN (58-2068734).

c. Under "Control/Claim Number", use Ambetter's claim number. It is listed on the remittance advice as "Payer CLM #"



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CLAIM NO.    19-239-0045-0  8/23/21  8/23/21 98941 ADJ, MOD OR RE-EXA    60.00
ID#          [redacted]     8/23/21  8/23/21 97014 ADJ, MOD OR RE-EXA    30.00
PATIENT #     6653301903    8/23/21  8/23/21 97012 ADJ, MOD OR RE-EXA    30.00
INSURED      [redacted]                                CLAIM TOTAL:    120.00
PATIENT      [redacted]
GROUP NO.  110000-001 PSHP (AM
PAYER CLM# U238MPE61930
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d. Under "Dates of Service", put the patient's date of service that you are appealing. (If it's a range of dates, write them out completely. i.e. 10/1/2020-10/4/2020)

e. Under "Member Name", put the patient's name that's appealing. Be sure to use the name listed on the patient's insurance card.

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

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2 Read the directions on the form to ensure you need to appeal and what level of appeal you need. Then under "Level of dispute", select the appropriate level.

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. (Level 1) *Request for Reconsideration* is a communication from the provider about a disagreement with the way a claim was processed.

b. (Level II) *Claim Dispute* 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 fits your request the best.

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 filing in 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 (please explain) _____

Regardless of the reason for your dispute, you ***must*** explain in detail why you are appealing. If there are multiple reasons or multiple codes, please provide details. (i.e. CPT code 98943 should be processed as a separate procedure.

4 Fill out the last section accordingly.

Requestor Name: _____

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

a. Under "Requestor Name", put the first and last name of the person requesting. (This can be the provider, CA, office manager, etc.)

b. Under "Requestor Phone Number", put your best contact phone number.

c. Under "Date of Request", input today's date.

5 When the form is completely filled out, address the envelope to the appropriate address. (Address depends on the level of dispute you chose.)

Mail completed form(s) and attachments to the appropriate address:

Ambetter from Peach State Health Plan
Attn: Level I - Request for Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Ambetter from Peach State Health Plan
Attn: Level II – Claim Dispute
PO 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:

- Please allow 45 business days for your appeal to be processed.
- If you are submitting a "Corrected Claim", you ***do not*** need to fill out this form.

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ambetter. FROM peach state health plan.

PROVIDER REQUEST FOR RECONSIDERATION AND CLAIM DISPUTE FORM

Use this form as part of the Ambetter from Peach State Health Plan Request for Reconsideration and Claim Dispute process.

All fields are required information

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 (Level II)** should be used only when a provider has received an unsatisfactory response to a Request for Reconsideration.
- The Request for Reconsideration or Claim Dispute must be submitted within 180 days for participating providers and 90 days for non-participating providers from the date on the original EOP or denial.
- *Any photocopied, black & white, or handwritten claim forms, regardless of the submission type (first time, corrected claim, Request for Reconsideration, or Claim Dispute) will cause an upfront rejection.*
- If the original claim submitted requires a correction, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

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 filing in 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 (please explain) _____

Requestor Name: _____

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

Mail completed form(s) and attachments to the appropriate address:

Ambetter from Peach State Health Plan
Attn: Level I - Request for Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Ambetter from Peach State Health Plan
Attn: Level II – Claim Dispute
PO Box 5000
Farmington, MO 63640-5000