Generations Healthcare HMO

Medicare Advantage Health Plans

Generations Claim Reconsideration Request Form

Instructions: This form is to be completed by – contracted physicians, hospitals, or other healthcare professionals to request a claim reconsideration for members enrolled in a **Medicare** benefit plan administered by Generations.
Mailing Address: PO Box 1747 OKC, OK 73101 Attn: Claim Reconsiderations

Physician ___ Hospital___ Other health care professional (Lab, DME, etc.)___ Date form Completed: _____

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

Member Information

Member ID: _____ Claim # _____ Date of Service: _____ Billed Charges: _____

Member Name: _____ Member Date of Birth: _____

Patient Name (if different from above): _____ Patient Date of Birth: _____

Physician/health care professional information

Physician Name (as listed on the claim and/or EOB): _____

Billing Tax Identification Number (TIN) _____ Email: _____

Contact Name: _____ Phone: _____ Fax: _____

Reason for Request

Please include or attach any information that might be helpful in making a final claim determination.

- ☐ 1. Previously denied as not timely filed *(Attach proof of timely evidence)*
  - *Electronic claims – confirmation that Generations or one of its affiliates received and <u>accepted</u> your claim.*
  - *Paper claims – a copy of screen print from your accounting software to show the date you submitted the claim.*
    - *Include proof that claim is for the correct patient and the correct visit.*
    - *Other insurance carrier's denial/rejection, EOB, letter indicating termed coverage, etc.*
- ☐ 2. Previously denied/ for additional information or inappropriate billing *(provide description and/or requested documents)*
- ☐ 3. Previously denied pending receipt of Primary insurance carrier EOB *(attach copy of primary EOB)*
- ☐ 4. Resubmission of corrected claim *(explain correction below)*
- ☐ 5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment *(explain below)*
- ☐ 6. Previously denied for no authorization *(explain details below – medical necessity does not supersede contract language that indicates prior notification is required)*
- ☐ 7. Other *(Please Explain)*

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A final determination will be made within 45 days of receipt, unless additional documentation is required. We will notify you within 30 days if additional information is needed.