

# 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 accepted 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*)

---

---

---

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.