Provider Reconsideration Form

Instructions: This form is to be completed by – contracted physicians, hospitals, or other healthcare professionals to request a claim review for members enrolled in a **Medicare Advantage** benefit plan administered by Generations Healthcare (HMO) or GlobalHealth Medicare (HMO).

Mailing Address: PO Box 1747 OKC, OK 73101 **Attn:** Provider Payment Dispute **Date:** _____

Physician: ☐ **Hospital**: ☐ **Other** (Lab, DME, etc.): ☐

Member Information

Member/Patient Name: _____ ID: _____

Claim #: _____ Date of Service: _____ Billed $: _____

Physician/Hospital/Health Care professional information

Vendor Name: _____ Billing Tax ID (TIN): _____

Contact Name: _____ Phone: _____

Reason for Request

Corrected Claim (attached)

- ☐ CPT
- ☐ Diagnosis (ICD-9 or ICD-10)
- ☐ Date of Service
- ☐ Billed charges
- ☐ DRG
- ☐ Modifier
- ☐ Other

Underpayment

- ☐ Per Contract
- ☐ Units
- ☐ Other

Claim Pended or Denied

- ☐ No authorization
- ☐ Authorization does not match
- ☐ Quality or Readmission
- ☐ Billed Inappropriately
- ☐ Proof of Timely Filing
- ☐ Primary EOB or COB information
- ☐ Itemized billing request
- ☐ Medical records

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

Including but not limited to: *Proof of timely evidence* and or **proof** *Generations Healthcare (HMO) or GlobalHealth Medicare (HMO)* **accepted** *your Electronic claim (277 report), (Claims rejected on the 277 do not suffice as proof of timely filing). Other insurance carrier's denial/rejection, EOB, letter indicating termed coverage, records, itemized billing, etc.*

Comments: *(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.