Provider request for reconsideration and claim dispute form

Use this form as part of the Ambetter from Home State Health **Request for Reconsideration and Claim Dispute** process. **All fields are required information.**

Provider Name	Provider Tax ID #
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 Home State Health Plan
Attn: Level I – Request for Reconsideration
PO Box 5010
Farmington, MO 63640-5010

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