Claim Adjustment or Appeal Request Form

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Use this form for member claims submitted to Payer ID 41822 to submit requests for reconsideration to adjust a claim, or file an official appeal. Submit one form per claim.

Type of Request: (Select the type of request.)

- ❍ Request for Reconsideration
- ❍ Official Appeal

Submission Type: ❍ This is my first request submission
❍ This is my second request submission and I've provided new documentation

NOTE: Appeals must go through the official appeal process. Appeals related to a claim that was denied for lack of prior authorization must be received within 60 days of the denial date. All other adjustments and appeals must be received within 12 months of the original denial date.

Provider Information

Practitioner Name:	Tax Identification Number (TIN):
Facility/Group Name:	
Provider Number (10 or 11 digits):	Provider Patient Account Number:

Contact Information

Requester:	Phone Number: ( )	Fax Number: ( )	Date:

Claim Information

Member (Patient) Name:	
Member Group and ID Number:	Date(s) of Service:
Claim Number:	Denial / Reason Code(s):

Reason For Request

- ❍ Timely filing – claims submitted beyond 180 days from DOS or 12 months from the disallow date
- ❍ Pricing – incorrect payment or application of benefits
- ❍ Eligibility – payment issues for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- ❍ Medical policy – request a determination of medical necessity or a denial for failure to obtain prior authorization. **60 days in the case of lack of prior authorization.** Supporting documentation is required.
- ❍ Code review – request of coding decision; supporting documentation required. Requires completion of coding review request topics section.
- ❍ Other ________________________

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Supplemental Documentation Attached

- ❍ Remittance Advice ❍ Refund ❍ Medical Records
- ❍ Other (e.g. timely filing documentation, such as practice management notes) ___________________________

Coding Review Request (Additional Information)

Select the topic that best describes the denial received and submit a corrected claim if appropriate. When requesting a review of a denied code, please include a brief explanation with supporting documentation.

❍ Code Bundling	CARC 234/RARC M15, CARC M20/RARC 16, CARC 97,150,231, CARC B16
❍ Maximum Units / Frequency of Service	CARC 151
❍ New Patient Visit Denial	CARC B16
❍ Invalid / Missing / Inappropriate Modifier	CARC 4
❍ Qualifying Service Not Received	CARC A1/RARC N122, CARC B15
❍ Global Surgery Denial	CARC 234/RARC M144 or N525
❍ Assistant/Team/ Co-Surgeon	CARC 54
❍ Diagnosis Denial	CARC 9, 11
❍ Place of Service Denial	CARC 5
❍ Duplicate Denial	CARC 18
❍ Non-Covered Procedure Denial	CARC 96
❍ Unlisted / Miscellaneous / Code Denial	CARC 16/RARC N350, CARC 133

❍ Other: (enter information to indicate code to be reviewed and/or CARC/RARC in question _________________

NOTE: Patient weight required for review of drug denials _________________

Additional Comments:

Total number of pages attached (including supporting documentation): _________________

After you have received a response for your initial request and if you still don't agree, you may appeal by adding your rationale below and attach supporting documentation. Please submit to the address below.

Submit the request and supporting documentation:

Mail:
Dean Health Plan by Medica
PO Box 211404
Eagan, MN 55121

Fax: 1 (952) 992-1427

Submit this form electronically