PROVIDER REQUEST FOR OUT OF NETWORK PAYMENT EVALUATION

Ambetter from Coordinated Care Corporation

All fields are required - One (1) form per member

Provider Name	**Provider TIN**
Claim Number(s)	**Service Date(s)**
Member Name	**Member Number**

Please check one (1) box below:

☐ **Out of Network Payment Evaluation** - You received an Explanation of Payment (EOP) and disagree with the initial payment described by remittance code **EXaD = PAY: PAID PER BALANCE BILLING PROTECTION ACT.**

☐ **Request for Reconsideration or Claim Dispute** - Your request is regarding another reason not described above, i.e. no authorization, untimely filing, global/unbundled procedure, duplicate claim. **This is not the correct form,** please refer to https://ambetter.coordinatedcarehealth.com/provider-resources/manuals-and-forms.html and fill out the Claim Reconsideration and Dispute Form (PDF) - follow the instructions within this form for submission.

In the area below, please clearly explain your reason for the "Out of Network Payment Evaluation" If additional information or documents are necessary to support your explaination, please attach them in your email.

Requestor Name: _____

Requestor Email Address: _____ **Date of Request:** _____

Please attach this form and a copy of the EOP(s) with the claim number(s) to be evaluated and email your request to OONeval@coordinatedcarehealth.com

Ambetter will review your request for out of network payment evaluation in accordance with Washington State SSHB 1065.

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