



**PROVIDER REQUEST FOR RECONSIDERATION AND CLAIM DISPUTE FORM**

Use this form as part of the Ambetter from PA Health & Wellness Request for Reconsideration and Claim Dispute process.

All fields are required information

<b>Provider Name</b>	<b>Provider Tax ID #</b>
<b>Control/Claim Number</b>	<b>Date(s) of Service</b>
<b>Member Name</b>	<b>Member (RID) Number</b>

- 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 PA Health & Wellness**  
**Attn: Level I - Request for Reconsideration**  
**PO Box 5010**  
**Farmington, MO 63640-5010**  
**Fax (833) 957-0438**

**Ambetter from PA Health & Wellness Attn: Level II –**  
**Claim Dispute PO Box 5000**  
**Farmington, MO 63640-5000**