



# 1199SEIU Benefit Funds

Medical Claims Reconsideration, PO Box 717, New York, NY 10108-0717

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## CLAIM RECONSIDERATION REQUEST

COMPLETE A SEPARATE FORM FOR EACH CLAIM • PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Date: \_\_\_\_\_

Patient name: \_\_\_\_\_

Health ID #: \_\_\_\_\_

Claim number: \_\_\_\_\_

Original claim:  Paper  Electronic

Diagnosis code: \_\_\_\_\_

Rendering provider name: \_\_\_\_\_

Facility/Group name: \_\_\_\_\_

Provider Tax ID #: \_\_\_\_\_ Provider NPI #: \_\_\_\_\_

Amount billed: \_\_\_\_\_ Amount paid: \_\_\_\_\_

Date(s) of service: \_\_\_\_\_ Date paid: \_\_\_\_\_

**REASON FOR RECONSIDERATION: Indicate the reason(s) why you are filing this request (check all that apply):**

- 1. Claim was previously denied as "Exceeds Timely Filing" (*Attach proof of timely filing*)
- 2. Claim was previously denied with request for clarification/additional information (*Attach requested documents*)
- 3. Claim was previously denied due to a lack of information regarding "Coordination of Benefits" information (*Attach primary carrier's EOB*)
- 4. Claim was previously denied due to submission of incorrect information (*Explain correction below*)
- 5. Claim was previously denied due to a dispute of the applied contracted rate (*Explain below*)
- 6. Claim was previously denied with request for revisions that follow Correct Coding Initiative (CCI) guidelines for bundled claims (*Attach revised coding and explain below*)
- 7. Claim was previously denied for lack of authorization/medical necessity (*Attach proof of authorization/clinical documentation*)
- 8. Claim was previously denied because an incorrect Tax Identification Number (TIN) was provided
- 9. Claim was previously denied because member was deemed ineligible for services provided, but member is eligible
- 10. Other (*Explain here*): \_\_\_\_\_

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Reconsideration request must be submitted within 180 days of the date the claim was originally denied or paid.