1199SEIU Benefit Funds
PO Box 345 • New York, NY 10108-0345 • Tel: (646) 473-9200 • Outside NYC area codes: (800) 575-7771 • www.1199SEIUBenefits.org

HOSPITAL CLAIM RECONSIDERATION REQUEST FORM

Please print clearly in blue or black ink. You must complete a separate form for each claim.

Member's full name

Member ID #

Patient's full name

Patient's date of birth

Claim number

Original claim: ☐ Paper ☐ Electronic

ICD-10 code CPT code

HCPCS code DRG code

Rendering facility/group name

Provider's Tax ID # (TIN)

Provider's National Provider Identifier # (NPI)

Amount billed

Amount paid

Date(s) of service

Date paid

NOTE: This form should not be used for routine claim status requests. Please check your claim status by calling our Interactive Voice Response system at (888) 819-1199 or by using NaviNet through the "For Providers" tab at **www.1199SEIUBenefits.org.**

REASON FOR RECONSIDERATION REQUEST

Please explain why you are filing this request (check all that apply):

☐ Claim was previously denied as "Exceeds Timely Filing." ***(Attach proof of timely filing)***

☐ Claim was previously denied with request for clarification/additional information. ***(Attach requested documents)***

☐ Claim was previously denied for lack of "Coordination of Benefits" information. ***(Attach primary insurance carrier's Explanation of Benefits)***

☐ Claim was previously denied for lack of authorization/medical necessity. ***(Attach proof of authorization/clinical documentation)***

☐ Claim was previously denied because 1199SEIU member was deemed ineligible for services provided, but 1199SEIU member is eligible for services.

☐ Claim was previously processed with an incorrect provider Tax ID Number (TIN). ***(Explain under "Other")***

☐ Claim was previously processed with an incorrect contracted rate. ***(Explain under "Other")***

☐ Claim was previously processed with an incorrect Diagnosis Related Group (DRG). ***(Attach supporting documentation)***

☐ Claim was previously processed with a request for revisions that follow Correct Coding Initiative (CCI) guidelines for bundling claims. ***(Attach supporting documentation)***

☐ Other ***(Explain below)***

Hospital Claim Reconsideration Request Forms must be submitted within 180 days of the date the claim was originally denied or paid.

NOTE: This reconsideration request is NOT considered an administrative appeal under the terms of the Plan or under the regulatory provisions of the Employee Retirement Income Security Act of 1974 (ERISA appeal). An assignment of benefits does not confer an independent right to an ERISA appeal of a Plan determination. In order for a "Non-Participating Provider" to represent a patient in an ERISA appeal, the patient must sign and submit a Benefit Fund Appeal Representation Authorization Form, following the initial claim determination. All "Participating Providers" have agreed, by way of contract, that payment disputes with the Fund may only be addressed through the contractual process and do not involve the patients.

AFHOS02 • 3/17 • HOSPITAL CLAIM RECONSIDERATION REQUEST