Claim Adjustment or Appeal Request Form

Use this form for member claims submitted for the Payer IDs listed in the table below to submit requests for reconsideration to adjust a claim, or file an official appeal. Submit one form per claim.

94265	**12422**	**71890, 53589, or 88090**	**MEDM1**	**41822**
send to: Medica PO Box 30990 Salt Lake City, UT 84130	send to: Medica PO Box 21051 Eagan, MN 55121-0051	send to: Medica PO Box 211435 Eagan, MN 55121-0051	send to: Medica PO Box 21342 Eagan, MN 55121-0342	send to: Medica PO Box 211404 Eagan, MN 55121
Or fax this form to: 1 (801) 994 1076 Or submit this form electronically	Or fax this form to: 1 (952) 992 1427 Or submit this form electronically	Or fax this form to: 1 (952) 992 3024 Or submit this form electronically	Or fax this form to: 1 (952) 992 3899 Or submit this form electronically	Or fax this form to: 1 (952) 992 3024 Or submit this form electronically

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

(Continued on page 2)

❍ 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_____

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
❍ 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 do not agree, you may appeal by adding your rationale below and attach supporting documentation. Please submit to the appropriate address on the previous page.