

CLAIM RECONSIDERATION REQUEST FORM



Claim Number(s)	Phone Number	Contact Name	Provider Facility
Member Name	Member ID Number	Date of Service	Date of Submission

Reason you are requesting review for this claim: (Check one)

- Corrected Claims
- Subrogation/Workers Compensation/Motor Vehicle Accident/Third Party
- Coordination of Benefits
- Initial Credentialing
- OB/GYN Package Billing/Antepartum Care
- Received incorrect insurance information on date of service
- Resubmission, no response from previously submitted claim
- Assistant Surgeon
- Other: _____

Explanation:

Required Attachment:

1. EOP on this claim
2. Required Documentation as outlined in policy: *(Check all that apply)*
 - Log of when claim was sent to clearing house
 - Proof of what insurance information was given at DOS
 - Photo copy of incorrect insurance card that was presented
 - Notes documenting when the claim was sent
 - Requisition form from referring Provider's office
 - Copy of documented attempts to obtain insurance information
 - Corrected claim and medical record
 - Date of delivery
 - Work Comp denial letter, MVA denial/response letter
 - Copy of the primary carrier's Explanation of Payment

Preferred method of response: (check one)

- Mail: Address: _____ City _____ State _____ Zip Code _____
- Fax: Fax number: _____
- Email: Email Address: _____

Sanford Health Plan's policy on Timely Filing and claim reconsiderations is as follows:

Providers will be granted a one time review for claim reconsiderations if they feel their claim(s) was processed incorrectly. Follow up on claims processed with regards to denials, reimbursement levels, or other Sanford Health Plan determinations that effect claims processing must be submitted within 180 days from the date of service. If the claim is past the 120 day filing period, follow up on claims must be made within 60 days from the date the Explanation of Payment was issued to the provider. After this time frame has expired, claims will no longer be allowed to be reviewed.

By policy, Sanford Health Plan is required to process a "clean claim" within 30 days of receipt of the claim and 60 days for a "non-clean" claim. Therefore, all claims are to be paid or processed within 60 days.

Follow up is very important: If an EOP is not sent out for a claim, it is imperative that a call is made to the Provider & Payor Relations department at 1-800-601-5086 to obtain claim status. Providers are also strongly encouraged to sign up for myHealthPlan to find out claim status at: www.sanfordhealthplan.com

Determination: Approved Denied

Reviewed by (Sanford Health Plan Representative): _____ Date: _____

Reason: _____

Please fax or mail this form along with any other documentation to Sanford Health Plan:
 Attention: Provider & Payor Relations • PO Box 91110 • Sioux Falls, SD 57109-1110
 Fax: (605) 328-7224

PROCEDURE: Sanford Health Plan (the Plan) requires that all participating providers must submit all claims to the Plan within 120 days from the date the cost was incurred. Charges that are denied due to untimely filing may not be billed to the Member. When a Member receives Covered Services from a Participating Provider, the Plan will pay the Participating Provider directly, and the Member will not have to submit claims for payment. The Member's only payment responsibility, in this case, is to pay the Participating Provider, at the time of service, any Copay, Deductible, or Coinsurance amount which is required for that service.

Providers will be granted a one time review for claim reconsiderations if they feel their claim(s) was processed incorrectly. Follow up on claims processed with regards to denials, reimbursement levels, or other Plan determinations that effect claims processing must be submitted within 180 days from the date of service. If the claim is past the 120 day filing period, request for reconsideration on claims must be made within 60 days from the date the Explanation of Payment (EOP) was issued to the provider. After this time frame has expired, claims will no longer be reviewed.

Corrected Claims: Corrected claims, including but not limited to claims denied for unspecified or nonspecific coding (EXUN - DENIED-UNSPECIFIED/NONSPECIFIC DIAGNOSIS/PROCEDURE CODE), must be received within 180 days from the date of service. After this time frame has expired, claims will no longer be reviewed. Required documentation includes the corrected claim and a reference to the original Plan claim number.

Subrogation/Workers Compensation/Motor Vehicle Accident/Third Party: Claims must be received within 120 days from the date of notification or denial of claims. After this time frame has expired, claims will no longer be reviewed. Required documentation includes a copy of the denial or benefit exhaustion letter.

Coordination of Benefits: In the event the Plan is the secondary payer on health insurance benefits, claims must be received within 120 days from the date on the primary payer's EOP. After this time frame has expired, claims will no longer be reviewed. Required documentation includes a copy of the primary EOP.

Initial Credentialing: Claims must be submitted within the 120 day time frame from the date of service once the Provider has signed contracts. Providers are not to hold claims for notification of approved Credentialing or assignment of a Plan legacy number. Claim payments will be held upon completion of an approved Credentialed Status. If the Provider fails to meet credentialing requirements, claims will be processed and denied as the Provider not being eligible, which then becomes a Provider write-off.

OB/GYN Global Package Billing/Antepartum Care: Claims must be submitted within 120 days from the date of delivery. After this time frame has expired, claims will no longer be reviewed. Required documentation includes date of delivery.

Member Responsibility: Participating Providers must file claims to the Plan within 120 days after the date that the cost was incurred. If the Member fails to show his/her Plan ID card at the time of service and provider consequently bills the wrong Plan, then the Member may be responsible for payment of the claim after the Provider's timely filing period of 120 days has expired. The Plan only processes claims with this denial at the Provider's request. Both the Provider and the Member will receive an EOP and Explanation of Benefits (EOB) showing this denial. The Provider at this time accepts responsibility for discussing and handling any or all issues regarding the above claim with the Member. Required documentation includes a copy of the card including any information received on the date of service, requisition form from the referring Provider's office or copy of documented attempts to obtain insurance information.

Proof of Timely Filing: Plan Participating Providers are contractually obligated to file claims within 120 days. By policy, the Plan is required to process a "clean claim" within 30 days of receipt of the claim and 60 days for a "non-clean" claim. Therefore, all claims are to be paid or processed within 60 days. Required documentation includes screen prints from the billing system showing the date it was sent to the Plan. If claims are filed electronically, required documentation includes a dated screen print, with the documented name of the clearinghouse being used, of the claim being accepted without error by the Plan.

Newborn additions: A newborn is eligible to be covered from birth. Member's must complete and sign the Plan's enrollment application form requesting coverage for the newborn within 31 days of the infant's birth. Because of this timeframe allotted to add newborn dependents to a policy Providers should not file claims prior to the 31 days of an infant's birth. Claims received prior to the newborn being added to a policy will be denied or rejected electronically as Member not eligible. Providers will need to re-file claims after this allotted timeframe of 31 days for proper claims processing and reimbursement.

Assistant Surgeon: Requests for reconsideration of denied Assistant Surgeon charges must be received within 120 days of the date of service or 60 days from the EOP. Required documentation includes a reference to the Plan claim number, code(s) being asked for reconsideration and a copy of the medical records. Milliman Healthcare Management Guidelines has been used in conjunction with the National Committee for Quality Assurance (NCQA) standards for practice guidelines and medical management utilization. These guidelines are updated on a regular basis to include the latest research in developments throughout the medical system. Assistant Surgeon charges that are denied may not be billed to the member. Plan Participating Providers are contractually obligated to write off assistant surgeon fees that are not covered by the Plan.

Reimbursement Review: Requests for a review of reimbursement from the Plan on a code must be received within 120 days of the date of service or 60 days from the EOP. After this timeframe has expired, claims will not be reviewed.