PROVIDER CLAIM RECONSIDERATION REQUEST FORM

This form should be used if you would like a claim reconsidered or reopened. This is not a formal appeal. Requests must be submitted within 120 days of the date of service. If the request is filed after the 120-day timeframe, please include your reason for not making this request earlier. Please complete one request form for each claim.

The following criteria MUST be completed

Beneficiary Name: _____

Medicare/Health Insurance Number: _____

Original Claim Number: _____

Date of Service: _____

CPT/HCPCS Code: _____

Name of claimant or representative: _____

Request for clerical error reopening –

Reason for Reconsideration	Originally submitted as	Correction
Not a true duplicate		
Modifier omitted or submitted incorrectly		
Quantity billed submitted incorrectly		
Billed amount submitted incorrectly		
Other		

Redetermination Request: Dissatisfaction with the original claim determination

The reason I disagree with the initial determination is:

- ☐ The service was denied as a duplicate incorrectly
- ☐ The service was not overutilized
- ☐ Other

Additional Narrative:

Mail completed form to:
myNexus, Inc.
Attn: Claims Department
P.O. Box 991
Brentwood, TN 37024