myNEXUS

Attachment A

PARTICIPATING PROVIDER CLAIM RECONSIDERATION REQUEST FORM

This form should be used if you would like a claim reconsidered. This is not a formal appeal. Requests must be submitted within your specified timely filing timeframe agreement with myNEXUS. If the request is filed after the specified timely filing timeframe, please include your reason for not making this request earlier.

Please complete one request form for each claim you are submitting for reconsideration.

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 reconsideration –

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:

Please submit the completed form and attachments via secure and encrypted email to: aetnareconsiderations@myNEXUScare.com