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. Unless otherwise stated in your agreement, the request must be submitted within 90 **days** from the payment date. If the request is filed after 90 days, please include your reason for not making this request earlier.

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

Agency Contact Information :

Requester: ____________________________ Phone: _________________ Date: ________________

Email Address: _________________________________

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