myNEXUS

Attachment B

NON-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 365 days of the date of service. If the request is filed after the 365-day timeframe, please include your reason for not making this request earlier.

Please complete one request form for each claim you are submitting for reconsideration. Please include Hold Harmless Waiver with this form.

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:

WAIVER OF LIABILITY STATEMENT

Claim #:

Enrollee's Name:	Member ID:
Provider:	Dates of Service:
Health Plan:	

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature:	Date:

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