COVER SHEET INSTRUCTION

Claim Appeals, Reconsiderations & Disputes

Purpose and Usage of the Provider Cover Sheet

- The provider cover sheet should **only** be used by Providers to request a formal review of **Claim related denials. An appeal, reconsideration or dispute can be submitted using this form. See the definitions below.**
- For Medicaid plans this cover sheet can **accompany other submission materials and health place specific forms for claim related denials items only.**
- Providers are responsible for ensuring all submitted information is accurate and complete. Incomplete submissions may result in delays or denials.
- This form is not intended for bulk submissions.

Definitions

- **Claim Appeal/Reconsideration:** A review requested by a member, a member's representative, or a provider (to the extent permitted by applicable regulations & their provider contract) in response to an adverse initial determination made by the health plan.
- **Claim Dispute:** A review in response to an adverse initial determination made by the health plan regarding payment of a claim, requested by a provider who is not entitled to a regulated appeals process by federal/state mandate or by their provider contract.

When submitting this form fill out the following information to complete the request:

- **Provider Information:** Name, Tax ID, and NPI.
- **Member Information:** Name, Member ID, Date(s) of Service.
- **Claim Information:** Claim number, Date of last Explanation of Payment (EOP).
- **Reason for Request:** Explanation of reason for request, including applicable authorization numbers if applicable.
- **Provider's contact name and number** for any questions or further information.

(continued)

Required documentation for each submission in addition to the completed cover sheet:

- **Claim Appeal/Reconsideration:**
  - Appeal letter detailing the reason for the appeal (for appeals based on medical necessity).
  - Medical records pertinent to the claim denial.
  - Authorization proof if the claim was denied for no authorization.
- **Claim Dispute:**
  - Itemized bills or invoices for payment disputes.
  - Explanation of Benefits (EOB) from primary insurance for coordination of benefits issues.
- **All Submissions:**
  - Any additional documentation that supports the request, such as correspondence, additional medical records, or proof of timely filing.
- **Any incomplete submissions will not be processed and will be sent back for completion.**

Time Frames and Deadlines

- Appeals/reconsiderations and disputes must be submitted as required by regulations or specific contract from the date of the original Explanation of Benefits (EOB) or denial. Please refer to your Provider Manual for specific time frames.

Additional Notes:

- If the request involves multiple claims denied for the same reason, please reach out to your Provider Relations Representative for support on bulk submission.
- We recommend all providers to use the Provider Web Portal for submissions. If submitting request via portal submission, do not use this form. Please refer to your Provider Manual for Portal process.

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PROVIDER COVER SHEET

Claim Appeals, Reconsiderations & Disputes

This coversheet is to be used when you have a claim related **appeal, reconsideration, or payment dispute. It may be used by Providers for Marketplace plans.**

Fill out the form completely with clear identification of request and keep a copy for your records. Please submit **one cover sheet for each claim request to help ensure timely and accurate processing**. Your request will be processed **once all necessary documentation is received. See below check-list containing necessary documentation to attach for your appeal or dispute**. A resolution letter will be sent to the address on file.

✉ This form should be used when submitting your appeal/reconsideration or dispute and **mailed to the following address**:

Ambetter from Buckeye Health Plan
PO Box 5010
Farmington, MO 63640-5010

🖷 You may also fax the Appeal/Reconsideration request to **1-833-957-0438**.

Plan identification details:

Member ID: _____

☐ Marketplace

Please select what you are requesting:

☐ Claim Appeal
☐ Claim Payment Dispute
☐ Claim Reconsideration

Submission details: ☐ Par Provider ☐ Non-Par Provider

Provider/Facility name: _____

Provider Tax ID: _____

NPI: _____

Claim #: _____

Dates of Service: _____

Authorization # (if applicable): _____

Number of pages in request: _____

Please include the items below that are relevant for your submission.
Check each box indicating what is attached to the request:

☐ Medical records ☐ Itemized Bills ☐ WOL (Waiver of Liability, Medicare Non-Par Providers ONLY)
☐ AOR (Appointment of Representative, Medicare Non-Par Provider 3rd Party Appellants ONLY)
☐ Additional Information Provided (check box and list document type): _____

Reason for the request:

_____

Contact Person for Request: _____

Direct Phone Number for Contact Person: _____

Contact Person – Fax #: _____

Signature: _____ Date: _____