PROVIDER REQUEST FOR RECONSIDERATION AND CLAIM DISPUTE FORM

Use this form as part of the Ambetter from Absolute Total Care Request for Reconsideration and Claim Dispute Process.

Provider Name	Provider Tax ID #
Control/Claim Number	Date(s) of Service
Member Name	Member (RID) Number

• A **Request for Reconsideration (Level I)** is a communication from the provider about a disagreement with the manner in which a claim was processed.
• A **Claim Dispute/Claim Appeal (Level II)** should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.
• A Claim Dispute/Claim Appeal must be submitted on this claim dispute/appeal form, which can also be found on our website. The claim dispute form must be completed in its entirety. The completed claim dispute/appeal form may be mailed to:

Ambetter
Attn: Claim Dispute
P.O. Box 5010
Farmington, MO 63640-5010

• A Claim Dispute/Claim Appeal will be resolved within 30 calendar days. A provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

Level of dispute (please check):
☐ Level I - Request for Reconsideration (Attach medical records for code audits, code edits, or authorization denials. Do not attach original claim form.)
☐ Level II - Claim Dispute (Attach the following: 1. a copy of the EOP(s) with the claim numbers to be adjudicated clearly circled, 2. the response to your original Request for Reconsideration. Do not attach original claim form.)

Reason for Dispute (please check):
☐ Claim was denied for no authorization, but authorization # _____ was obtained
☐ Claim was denied for no authorization, but no authorization is required for this service
☐ Claim was denied for untimely error (attach proof of timely filing)
☐ Claim was denied for global/unbundled procedure (attach medical records)
☐ Claim was paid to the wrong provider
☐ Claim was paid for the incorrect amount
☐ Other: _____

_____

Requestor Name: _____

Requestor Phone Number: _____ **Date of Request:** _____

Mail completed form(s) and attachments to the appropriate address:
Ambetter, Attn: Claim Dispute, P.O. Box 5010, Farmington, MO 63640-5010

All requests for corrected claims, reconsiderations, or claim disputes must be received within 60 days from the date of the original explanation of payment or denial.