# REQUEST FOR CLAIM REVIEW FORM – Contracted Providers

MASS ADVANTAGE

Complete all information required on the "request for claim review form." Incomplete submissions will be returned unprocessed.

## Contact Information

If you have any questions please contact Member Services — HMO: (844) 918-0114, PPO: (844) 915-0234 (TTY: 711); October 1 – March 31, 8 a.m. - 8 p.m. EST, 7 days a week and April 1 – September 30, 8 a.m. - 8 p.m. EST, Monday – Friday.

Our mailing address is Mass Advantage, PO Box 830059, Birmingham, AL 35283.
Our fax number is (744) 701-1416.

## 1 General Information

Today's Date (mm/dd/yyyy)

Health Plan Name

## 2 Provider Information

Provider Name

Contact Name

National Provider Identifier (NPI)

Provider Address (include Suite #)

City

State

Zip

Phone Number

Fax Number

Email

*DEFKMRPRCLRV*

## 3 Member/Claim Information

| Member Name | Member ID |
|---|---|
| | |

Date(s) of Service (mm/dd/yyyy)

| Claim Number | Denial Code |
|---|---|
| | |

## 4 Review Type

Enter X in one box, and/or provide comment below, to reflect purpose of review submission.

- ☐ **Contract Term(s):** The provider believes the previously processed claim was not paid in accordance with negotiated terms.
- ☐ **Coordination of Benefits:** The requested review is for a claim that could not fully be processed until information from another insurer has been received.
- ☐ **Duplicate Claim:** The original reason for denial was due to a duplicate claim submission.
- ☐ **Filing Limit:** The claim whose original reason for denial was untimely filing.
- ☐ **Payer Policy, Clinical:** The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
- ☐ **Payer Policy, Payment:** The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
- ☐ **Pre-certification/Notification or Prior-Authorization or Reduced Payment:** The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
- ☐ **Request for Additional Information:** The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC codes, home infusion therapy).
- ☐ **Retraction of Payment:** The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).

☐ **MassHealth:** The MassHealth provider has received a Final Deadline Exceeded error message. MassHealth providers must only use this review type to submit claims for review to MassHealth. Use of this form for submission of claims to MassHealth is restricted to claims with service dates exceeding one year and that comply with regulation 130CMR 450.323.

☐ Other:

**4 Comments** (please print clearly below)

**5 Attach all supporting documentation to the completed "Request for Claim Review Form."**