REQUEST FOR CLAIM REVIEW FORM – Contracted Providers

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 Provider 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 219975, Kansas City, MO 64121-9975.
Our fax number is (816) 502-4585.

1. General Information

Today’s Date (mm/dd/yyyy) ____________

Health Plan Name ____________

2. Provider Information

Provider Name ____________

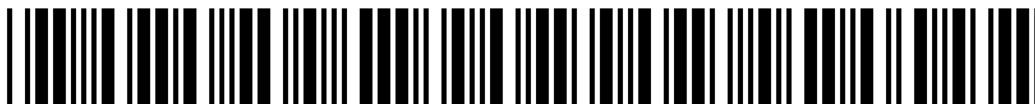
Contact Name ____________

National Provider Identifier (NPI) ____________

Provider Address (include Suite #) ____________

City ____________ State ____________ Zip ____________

Phone Number ____________ Fax Number ____________ Email ____________



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). Corrected bills should be submitted through the general claims' re-submission process.

[ ] **Retraction of Payment:** Payment or service line (e.g., not your patient, service not performed, etc.).

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