Provider Medicare Advantage Claim Reconsideration Form

- One form per Medicare Advantage member.
- All required fields are mandatory for submission.
- This form is not to be used in place of a replacement/void claim (e.g. Modifier changes Dx changes)
- For status checks and questions on how to fill out the form, please contact Aspirus Health Plan's Provider Assistance Center at 715-631-7412 or toll free at 1-855-931-4851.
- Mail or fax your completed form to:

  Aspirus Health Plan - Attn: CLAIMS
  PO Box 23
  Minneapolis, MN 55440-9975
  Fax: 715-787-7306

Please use the following grid below to determine if you are requesting an Adjustment, Recoupment or Appeal. Incomplete forms will be returned to provider without further consideration.

REASON FOR REQUEST	DESCRIPTION	ADJUSTMENT TYPE	SUPPORTING DOCUMENTATION
Payment Dispute	Provider Disagrees With Original Claim Payment Due To An Incorrectly Processed Claim.	Adjustment/Recoup Request	Copy Of Fee Schedule Or Provider Agreement
Authorization	Denied Previously For No Authorization.	Appeal	Medical Records And Rationale For Service Performed
Authorization On File	Authorization Now On File, Claim Requires Reprocessing.	Adjustment Request	Authorization Number
Timely Filing	Claim Submitted After Filing Deadline.	Appeal	Documentation Supporting Submission Of A Claim Within The Timely Filing Limits
Eligibility	Member Not Eligible At Time Of Service.	Appeal	Documentation Supporting Effective/Term Date
Medical Policy Review	Request To Change A Utilization Review Decision, Or An Initial Claim Decision Based On Medical Necessity Or Experimental / Investigational Coverage Criteria.	Appeal	Medical Records And Rationale For Service Performed
Code Review	Provider Disagrees With Original Claim Payment Due To Coding Methodology (I.E. Bundling, Frequency, Global, Unlisted, Place Of Service, Etc.).	Appeal	Rationale For Questioning Payment
Billed In Error	Claim Billed In Error.	Recoup Request	N/A

Provider Medicare Advantage Claim Reconsideration Form

PRODUCT SELECTION

Product: Choose Product

Request Type:

- ☐ Adjustment/Appeal Request
- ☐ Recoupment Request
- ☐ 2nd Request - 1st Claim Reconsideration Form Confirmation #:

CONTACT INFORMATION

Requester:

Phone: **Fax:**

Email:

Today's Date:

Address:

City:

State: **ZIP:**

BILLING PROVIDER INFORMATION

Are you a contracted Aspirus Health Plan provider? ☐ Yes ☐ No

Provider Name: **Tax ID:**

NPI Number:

MEMBER INFORMATION

Member Last Name: **Member First Name:**

Aspirus Health Plan Member ID:

Are you appealing on behalf of the member: ☐ Yes ☐ No

Aspirus Health Plan has partnered with UCare, based out of Minnesota, as the administrator for our Medicare Advantage Plan.

Provider Medicare Advantage Claim Reconsideration Form

CLAIM INFORMATION: (additional claims can be added at the end of the form)

Claim Number/ICN #: **Date of Service:**

Reason for request: Choose One

Detailed description for request:

If service denied, what is the reason for denial? (see EOP/835)**:**

Other (Be specific):

SUPPORTING DOCUMENTATION

- ☐ **Medical Records** (attach & bracket applicable documentation only)
- ☐ **Refund** (only if the claims date has exceeded 12 months)
- ☐ **Remittance Advice**
- ☐ **Other**

If other, please include details:

Additional claims can be added on the following pages:

Provider Medicare Advantage Claim Reconsideration Form

CLAIM #2 INFORMATION:

Claim Number/ICN #: **Date of Service:**

Reason for request: Choose One

Detailed description for request:

If service denied, what is the reason for denial? (see EOP/835)**:**

Other (Be specific):

CLAIM #3 INFORMATION:

Claim Number/ICN #: **Date of Service:**

Reason for request: Choose One

Detailed description for request:

If service denied, what is the reason for denial? (see EOP/835)**:**

Other (Be specific):