



Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

- Please submit a separate claim reconsideration request form for each request
- No new claims should be submitted with this form.

Member Information (Required Information)			
Line of Business: (circle one)	HPN	SHL	Medicaid
Member ID and Date of Birth:	Claim #:	Date of Service:	Billed Amount:
Member Last Name	First Name	MI	Expected amount owed:

Physician/Health Care Professional Information			
Tax Identification Number (TIN):	Physician Name/Facility or other health care professional (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):	Email Address:	Contact Name and Telephone Number:

Reason for request: (please circle applicable reason)

- Exceeds Timely Filing
- Additional Information
- Coordination of Benefits
- Resubmission of a corrected claim
- Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
- Prior Authorization/Referral denial
- Resubmission of "Bundled/Incidental" services
- Carve-Outs

(Explain below)

Please include what you are expecting from HPN/SHL regarding this Claim Reconsideration

Comments:

Required attachments:

- Copy of EOP - Claim Form is **ONLY** required for Corrected Claims Submissions
- Other required attachments as outlined in the Claims Reconsideration Reference Guide