Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

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