QualChoice® HEALTH INSURANCE

Request for Reconsideration

Do not use as an Appeal Form*.

This form to be completed by QualChoice contracted physicians, hospitals or other healthcare professionals requesting claim reconsideration for members enrolled in QualChoice health plans. Please submit a separate form for each claim. Form must be completed and submitted with required documentation. Incomplete forms may be returned. Please attach any additional information applicable to the request. Corrected claims should be submitted electronically. If the claim in question has had no payments to date or you are submitting additional information for initial review of payment, please forward to the address on the back of the patient's ID card.

Mail: QualChoice, P.O. Box 25610, Little Rock, AR 72221 | **Email:** CLReconsider@QualChoice.com
Form must be on top of all required documents being submitted.

Please check one: ☐ Physician ☐ Hospital ☐ Other Healthcare Provider

Section I. Member Information				
Member ID	Claim # (as listed on the EOB or RA)	Date of Service (as listed on the RA or EOB)	Billed Amount	
Member Name: Last		First	MI	
Street Address		City	State	Zip
Patient Name: Last *(if SAME as Member, mark SAME)*		First	MI	

Section II. Practitioner/Hospital/Other Healthcare Provider				
Tax Identification Number (TIN)	Phone No.	Email Address		
Physician Name (as listed on RA or EOB): Last		First	MI	
Street Address		City	State	Zip
Facility/Group Name		Contact Person		

Section III. Person Completing this Form		
Name	Phone No.	Email Address

Section IV. Reason for Reconsideration Request. You must check (✓) one of the following.

CLAIMS

- ☐ Previously denied/closed for additional information
- ☐ Duplicate charges (e.g., multiple charges with same CPT)—Provide medical record documentation.
- ☐ Global Period Dispute
- ☐ Payment received for wrong provider or member—Provide details in **Comments** section.
- ☐ Duplicate payment received. **Check One:** ☐ Recover Funds ☐ Refund Enclosed
- ☐ Claim Check/Claim edit denial (i.e., mutually exclusive, incidental, etc.)—Provide medical record documentation.
- ☐ Modifier Reimbursement—Provide medical record documentation.
- ☐ Medical Record Request—When sending requested medical records, attach the QualChoice request letter or provide claim #.

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- ☐ Claims Timely Filing—Provide Acceptance Report from EDI Vendor and demonstration of timely follow-up.
- ☐ Provider Fee Schedule/Contract Language—Please provide detailed explanation of your reconsideration request in the comments section.

Comments. Include detailed information as to the nature of your request.

Possible attachments for supporting documentation: ■ Copy of RA or EOB ■ Other required attachments as listed above

Clinical denials (such as not medically necessary, experimental and investigational or when claim amounts are provider liability) are not eligible for the reconsideration process and should be handled via **Provider Appeal Form, found at **QualChoice.com**. Select **Providers, Forms/Information**.*