Independent Review Reconsideration Form

Use this form to initiate a final reconsideration process before submitting a dispute to a third party for Independent Review.

Mail to:

From: _____

Phone: _____

_____

Required Information

Member/Recipient Name: _____ Member/Recipient ID#: _____

Date(s) of Service: _____ Remittance Advice Date: _____

Amount Billed: _____ Amount Paid: _____

Claim Number: _____ Pended Claim: ☐ Yes ☐ No

Denial Reason: _____ Denial Code: _____

Procedure Codes Billed: _____

To request reconsideration, providers have 180 days from the date a claim denied in whole, partially or recoupment date of a claim or the MCO failed to issue a RA within 60 calendar days.
Please use the space below to provide reason for dispute and any other necessary information, along with your attachments, to enable a thorough reconsideration.

_____

Signature: _____ Date: _____

Submit this completed form to:
Louisiana Healthcare Connections
Attn: Provider Solutions
P.O. Box 84180
Baton Rouge, LA 70884

The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with **§3111.B.1,** within 5 calendar days after the receipt of the request, and render a final decision by providing a response to the provider within 45 calendar days from the date of the receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

Act 204 of the 2021 Regular Legislative Session directed the Department of Health to promulgate Rules granting mental health rehabilitation service providers the right to an independent review of an adverse determination taken by a managed care organization that results in a recoupment of the payment of a claim based on a finding of **waste** or **abuse**.