Provider Claim Dispute Form
PAYMENT RECONSIDERATION & CLAIM APPEAL

Instructions
• Attach a copy of the Explanation of Payment (EOP) with the claim numbers to be reviewed clearly circled, and any other supporting documents.
• If multiple claims are included in the claim dispute, attach a list of the claim numbers on a separate document.
• Do not include this form with a corrected claim.
• Submit this form within 180 calendar days of the date on the last EOP.

MAIL FORM & ATTACHMENTS TO:
Louisiana Healthcare Connections
Claim Reconsiderations & Appeals
P.O. Box 4040
Farmington, MO 63640-3800

Provider Information

Date: ____________________________

Provider Name*: ____________________________  Tax ID*: ____________________________

Contact Name: ____________________________  Phone: ____________________________

Claim Information

Claim Number*: ____________________________  Date(s) of Service*: ____________________________

Member Name: ____________________________

Member ID: ____________________________

* Indicates a required field

This dispute is a:
☐ Request for Reconsideration: You disagree with the original claim outcome (payment amount, denial reason, etc.). Check here if this is the first time you are requesting a review of the claim.
☐ Claim Appeal: You disagree with the outcome of the Request for Reconsideration.

Reason for the reconsideration or appeal (check all that apply):
☐ Claim denied for no authorization, but authorization number was obtained.
☐ Claim denied for no authorization, but no authorization is required for this service
☐ Claim denied for member not eligible, but member was eligible on DOS (attach eligibility information)
☐ Claim denied and member was retro-enrolled (attach RA indicating void)
☐ Claim denied for “Incomplete or missing sterilization form,” but one was submitted with claim (attach completed form)
☐ Claim not paid per the terms of my contract with LHCC (attach relevant reimbursement section)
☐ Claim denied for “Past Timely Filing” (attach proof of timely filing)
☐ Claim paid the incorrect amount (attach calculation of expected payment and supporting information)
☐ Claim denied and we would like it reconsidered (attached medical record documentation)
☐ Other (please explain): ____________________________