# Independent Review Provider Reconsideration Form

Mail to:

From:

Phone:

Email:

Email:

## 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:

Reason(s) for Complaint:

☐ Untimely Filing ☐ Claim Recoupment Error ☐ Recoupment Due to Waste or Abuse

☐ Medical Necessity ☐ Neither Paid nor Denied ☐ Lack of Authorization

☐ Level of Care ☐ Claim Paid Incorrectly ☐ Other

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:

***The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with **R.S. 46.460.81,** 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.***