Provider Claims Reconsideration Form

Purpose: To collect the necessary information to review and make a determination on a request for claim reconsideration.

IMPORTANT! Please review the types of claims submissions below. Follow the appropriate steps to prevent delays in reviewing your request. The instructions differ based on the type of submission.

Action/Request	Purpose	Additional Info	Next Step
Claim Reconsideration Form	To dispute the outcome of a previously submitted and processed claim.	Claim information originally submitted was complete and accurate (to your knowledge) and you are requesting a secondary review.	PROCEED! Complete this form as instructed below.
Corrected Claim	To replace a previously submitted and processed claim.	A corrected claim might include providing a referral number or rendering NPI originally omitted, different procedure(s) or diagnosis codes, or any other information that would change the way the claim was originally processed.	STOP! Do not use this Claims Reconsideration Form. – Follow standard Corrected Claims submission procedures as found in the CCN Provider Handbook.
Voided Claim	To cancel an already submitted and processed claim.	A voided claim must be identical to the original claim that it is intended to cancel.	STOP! Do not use this Claims Reconsideration Form. – Follow standard Voided Claims submission procedures as found in the CCN Provider Handbook.

Claims Reconsiderations **– Expectations**

DO	DON'T
• **Do** submit a reconsideration form for each individual claim. • **Do** include supporting documentation. • **Do** provide a clear and detailed explanation to support your reconsideration request. • **Do** complete ALL fields in the reconsideration form. • **Do** proceed with the instructions on the next page if your intent is to submit a Claim Reconsideration Request.	• **Don't** include documentation that is not relevant to the claim being reconsidered. • **Don't** include medical records in your submission. • **Don't** submit multiple claims on one reconsideration form (will be rejected). • **Don't** use or submit this form if your intent is to submit a Corrected or Voided Claim.

Important - Timely Filing!

- Verify the date of original claim payment or denial, prior to proceeding with the remaining instructions. Reconsideration Forms must be submitted within *90 days* of the ***original claim processed date***.
  - Reconsideration Forms submitted outside of the timely filing period will be denied accordingly.
  - A rejected Reconsideration Form is not considered "timely". You must submit a COMPLETE and VALID Reconsideration Form within the 90-day period for it to be accepted and reviewed as "timely".
- Complete the Reconsideration Form in its entirety.

Provider Claims Reconsideration Form

Print the completed Reconsideration Form. *Attach additional pages, if needed.*

Add your supporting documentation to the completed Reconsideration Form. Supporting documentation should be relevant to the reconsideration request. **DO NOT** include medical records.

Examples of supporting documentation include (*but are not limited to*):

- Provider Remittance Advice (PRA)
- Proof of Timely Submission to a VA payer – ***only VA, Optum, or TriWest are acceptable***
- Claim Forms
- Claim Rejection Letter

Mail the completed form and all supporting documentation to:

TriWest CCN Claims
P.O. Box 42270
Phoenix, AZ 85080-2270

Questions? Contact 877-226-8749

Select the applicable Veteran program: ◯ CCN ◯ PC3

Reason for Provider Reconsideration Request (select one):

◯ Authorization ◯ Pricing ◯ Timely Filing ◯ Other

If 'Other' selected above, please explain the reason for the Claim Reconsideration Request:

Date of Reconsideration Request: (MM/DD/YYYY)

Date of Original Claim Determination: (MM/DD/YYYY)

Provider Information

Provider Name:

National Provider Identifier (NPI): Tax Identification Number (TIN):

Billing Street Address:

City: State: ZIP:

Provider Contact Information

Provider Contact Name:

Contact Phone: Contact Email:

Check if the same as Billing Address: ☐ Address:

City: State: ZIP:

Provider Claims Reconsideration Form

Veteran Information

Last Name: First Name:

ICN, EDIPI, or last four of SSN: Date of Birth:

Claim Information

VA Authorization Number: Claim Number:

Authorization Validity Dates: VAMC:

☐ Check box if URGENT CARE (No Authorization # Required)

Date(s) of Service:

Reconsideration Request Explanation

Describe your concern(s) regarding the outcome of the claim. Please provide details to support your Reconsideration Request. Be as specific as possible and try to describe events in the order in which they occurred. You may attach additional pages or supporting documentation, as needed.