Provider Reconsideration and Appeal Request Form

Use this form to request one of the following:

- **Claim Reconsideration**
- **Claim Appeal**
- **Authorization Appeal**

Provider Name	Provider Tax ID #
Control/Claim Number	Date(s) of Service
Member Name	Member (RID) Number

- A **Claim Reconsideration** is a communication from the provider about a disagreement with the manner in which a claims was processed.
- A **Claim Appeal** is a formal written request for additional payment of a previously adjudicated electronically submitted Clean Claim.
    - The Claim Appeal must be submitted within 180 calendar days for participating providers from the date on the original EOP or denial.
    - *Any photocopied, black & white, or handwritten claim forms, regardless of the submission type (first time, corrected claim, Claim Reconsideration, or Claim Appeal) will cause an upfront rejection.*
    - If the original claim submitted requires a correction, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.
    - Examples of a Claim Appeal (but not limited to):
        1. Claim did not pay per provider expectations/contract rate
        2. Disagree with failure to obtain necessary authorization denial
        3. Disagree with unbundling payment policy denial
        4. Disagree with timely filing denial
        5. Claim paid to the wrong provider
- An **Authorization Appeal** is a formal written request to reconsider an authorization denial (pre or post-service).
    - The Authorization Appeal must be submitted within 60 calendar days of the date on Home State's notice of adverse determination or per the provider's contract
    - Examples of an Authorization Appeal (but not limited to):
        1. The plan issued an authorization place of service for outpatient and the hospital bills an inpatient service or vice versa
        2. Denials for levels of care that do not match authorized services
        3. A hospital does not obtain a prior authorization for a newborn Medicaid member with an extended stay whose mother was covered by the Plan at the time of delivery
        4. If the original service did not require an authorization; however, once the procedure began the member required a different service or place of service that requires an authorization that was not obtained within the retrospective timeframe listed in the Plan's provider manual
        5. If the original service did not require an authorization; however, the patient was subsequently admitted overnight as outpatient in a bed and the facility failed to obtain authorization for admission
        6. A retrospective authorization from a provider with contractual "retro-rights" where it was identified that extenuating circumstanced were present to allow for retrospective prior authorization review.
        7. 30-day readmission denials
        8. Procedures that no prior authorization is required; however, when the procedure is billed the diagnosis on the claim is not payable per our Plan's policy

Please select one of the following:

□ **Claim Reconsideration** Attach the following: 1. Medical records for code audits, code edits or authorization denials. Do not attach original claims form.	□ **Claim Appeal** Attach the following: 1. A copy of the EOP(s) with the claim numbers to be adjudicated clearly circled; 2. The response to your original Claim Reconsideration. Do not attach original claim form.
	□ **Authorization Appeal** Attach the following: 1. A letter outlining the reason for your request 2. Applicable medical records supporting your request

Reason for Claim Appeal (please check):

□ Claim was denied for no authorization, but authorization #----------was obtained

□ Claim was denied for no authorization, but no authorization is required for this service

□ Claim was denied for untimely filing in error (attach proof of timely filing)

□ Claim was denied for global/unbundled procedure (attach medical records)

□ Claim was paid to the wrong provider

□ Claim was paid for the incorrect amount

□ Other:(please explain)

Requestor Name:
Requestor Phone Number:
Date of Request

You can submit your request (must be submitted in writing) via one of the following:

Claim Reconsideration 1. Submit online via the Secure Web Portal* Provider.HomeStateHealth.com 2. Mail completed form(s) and attachments to: Home State Health Plan **Attn: Claim Reconsideration** PO Box 4050 Farmington, MO 63640-3829 ***All submissions sent through the portal allow for real-time tracking of Reconsideration Status.**	**Claim Appeal** 1. Mail completed form(s) and attachments to: Home State Health Plan **Attn: Claim Appeal** PO Box 4050 Farmington, MO 63640-3829
	Authorization Appeal 1. Mail completed form(s) and attachments to: Home State Health Plan **Attn: Authorization Appeal** 11720 Borman Dr. St. Louis, MO 63146 FAX: 877-309-6762

If you need to speak with a Home State Provider Services Representative, please call 1-855-694-HOME (4663) Monday thru Friday, 8AM-5PM or visit our website at www.homestatehealth.com.