Independent review provider reconsideration form

Mail to		
Name:		
Mailing address:		
City:	State:	ZIP code:
Email:		

From		
Name:		
Mailing address:		
City:	State:	ZIP code:
Phone:	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, health care professionals have 180 days from the date a claim is denied in whole or partially. Or, they have 180 days from the recoupment date of a claim. A request for reconsideration can also be requested if UnitedHealthcare failed to issue a remittance advice. Please use the following space to provide the reason for your dispute plus any other necessary information, including any attachments.

Signature:	Date:

Note: The MCO shall acknowledge in writing receipt of a reconsideration request submitted in accordance with **R.S. 46.460.81**. This must be within 5 calendar days after the request is received and render a final decision by providing a response to the provider within 45 calendar days from the date the request is received for reconsideration, unless another time frame is agreed upon in writing by the health care professional and the MCO.

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