



Claim Review Request Form

Complete all the information that is required (*) on the "Claim Review Request Form". If the information is submitted incomplete, submissions will not be processed and will be returned.

Please direct any questions regarding this form to Claims@kaloshealth.org.

Today's Date :		Health Plan Name :	
* Signifies required field(s)			
Provider Information			
* Provider Name :		* Contact Name :	
* National Provider Identifier (NPI) :		* Contact Phone Number :	
Contact Fax Number :		Contact Email :	
* Contact Address :			
Member / Claim Information			
* Member ID :		Member Name :	
* Date(s) of Service			
* Claim Number :		* Denial Code(s) :	
* Review Type			
Checkmark in one box, and/or provide below, to reflect purpose of review submission			
<input type="checkbox"/>	Contract term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms.		
<input type="checkbox"/>	Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.		
<input type="checkbox"/>	Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (ex: units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made.		
<input type="checkbox"/>	Duplicate Claim: The original reason for denial was due to a duplicate claim submission.		
<input type="checkbox"/>	Filing Limit: The claim whose original reason for denial was untimely filing.		
<input type="checkbox"/>	Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.		
<input type="checkbox"/>	Payer Policy, Payment: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.		
<input type="checkbox"/>	Pre-Certification/Notification or Prior-Authorization or Reduced Payment: The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.		
<input type="checkbox"/>	Referral Denial: The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.		
<input type="checkbox"/>	Request for additional information: The requested review is in response to a claim that was originally denied due to missing or incomplete information.		
<input type="checkbox"/>	Retraction of Payment: The provider is requesting a retraction of entire payment or service line.		
<input type="checkbox"/>	Other:		
Comments (Please print clearly below) :			

Attach all supporting documentation to the completed "Claim Review Request Form".