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.

Health Plan Name :

Please send completed form and supporting documentation 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

	Contract term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms.
	Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.
	Corrected Claim: The previously processed claim (paid of denied) requires an attribute correction (ex: units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made.
	Duplicate Claim: The original reason for denial was due to a duplicate claim submission.
	Filing Limit: The claim whose original reason for denial was untimely filing.
	Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
	Payer Policy, Payment: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
	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.
	Referral Denial: The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
	Request for additional information: The requested review is in response to a claim that was originally denied due to missing or incomplete information.
	Retraction of Payment: The provider is requesting a retraction of entire payment or service line.
	Other:

Comments *(Please print clearly below)* :

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