Provider Post Service Claim Reconsideration/Appeal Form

Submit a separate form for each claim appeal or reconsideration (i.e., one form per claim). Applicable filing limit standards apply.

Provide the following information:

Today's date: _______/_______/_______ Member's ID: ______________________________

Date of service: _______/_______/_______ Member name: ______________________________

Provider's contact name: ______________________________

Claim #: ______________________ Provider phone #: ______________________

Select type of request:

Please note: OHP denials for being out of network will not be reconsidered and Post Service Claim Reconsiderations/Appeal forms will be closed without review.
If the missing information is related to an auth denial this is considered an appeal.
If the provider did not get an auth then it is considered a retro auth request.

☐ **Reconsideration for Payment – Supporting documentation MUST BE attached.**

- Retro enrollment updates
- Overpayment errors
- Timely filing denials
- Denied for missing information/documentation
  - » Itemized bills or chart notes
  - » Primary EOB
  - » Consent forms (missing, incomplete or corrected)

☐ **Retro Auth Request - Supporting documentation MUST BE attached (reason why prior auth not requested)**

- Auth issue - denied no auth

☐ **Claim Appeal- please check one if known:**

- ☐ Auth issue - denied at time of authorization
  - » Requires additional information
- ☐ Auth issue - denied inconsistent with auth
- ☐ Auth issue - denied authorization units exceeded
- ☐ Auth issue - dental
- ☐ Auth issue - DME, HH, EPIV, limb prosthetics
- ☐ Auth issue - pharmacy

NOTE: Submissions by non-par Medicare providers must include a completed Waiver of Liability Statement. The model waiver of liability notice is available in both Microsoft Word and PDF formats from the CMS website: *cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html*

Corrected Claims - DO NOT USE this form. Use last digit of the Bill Type for UB 6-Corrected claim, 7-Replacement of prior claim or Box 22 of HCFA and resubmit your claim via EDI or mail.

Fax to:
Claim Appeals Coordinator
Fax numbers:
Medicaid 503-416-8115
Medicare 503-416-1330

Mail to:
CareOregon Claims Department
Reconsiderations/Claim Appeals
PO Box 40328
Portland OR 97240-9934