Provider Claim Adjustment/Reconsideration Form

This request is a:

- ☐ **Claim adjustment (correction/resubmission):** A request to change the initial claim.
  - To correct a billing error (invalid or incorrect information) in the initial claim submission.
  - To reprocess a partially denied claim. Adjustment requests related to partially denied claims should be submitted in their entirety as originally filed.
- ☐ **Claim reconsideration:** Submitted when a provider disagrees with how a clean or adjusted claim was processed.
  - Examples include but are not limited to:
    - Denials related to code edit or authorization. Requests related to code edit or authorization denial require medical records and must accompany the request for reconsideration.
    - Payment amount which does not align with expected payment.

Note: Adjustment and reconsideration requests must be submitted within 365 calendar days of the date of service and may be requested through the secure provider portal found on our website at absolutetotalcare.com. Please use this form only if you wish to send your request via mail.

All fields in the boxes below are required information:

Provider/Group Name	Provider Tax ID Number	Provider NPI Number	Provider County	Date of Service	Date of Last EOP
Member Name	**Member ID Number**	**Claim Number***	**Name of Person Completing Form**	**Phone Number**	**Email Address**

*Enter multiple claim numbers

Reason for adjustment (correction/resubmission) or reconsideration request (please check):

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was submitted with incomplete or invalid information.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for untimely filing in error (proof of timely filing should be attached).
- ☐ Claim was paid to wrong provider.
- ☐ Claim was paid for incorrect amount.
- ☐ Other (please explain below):

_____

_____

Date of Request: _____ Requestor Name: _____

Requestor Phone Number: _____

Please submit a copy of the EOP(s) with claim(s) to be adjusted clearly circled. If claim(s) also required a correction, such as a valid procedure code, location code, or modifier, please also include a copy of that page from your EOP with the claim circled, along with a copy of the new, corrected CMS-1500 or UB-04 Form.

Mail completed form(s) and attachments to: Absolute Total Care, P.O. Box 3050, Farmington, MO 63640-3821.

Absolute Total Care's Claims Department will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment; or
2. A determination that reprocessing is not appropriate and issuing you a letter to that effect.

To dispute the outcome of a previously reconsidered claim, please submit your request on a Provider Dispute Form, which can be found on the Provider Manuals and Forms page of our website.

If you have any questions, please call Provider Services at 1-866-433-6041.