Date: ____________________

☐ Contracted Provider  ☐ Non-Contracted Provider

Please complete the following form to help expedite the review of your claims reconsideration.

Is this a:
- ☐ Request for Reconsideration: You disagree with the original claim outcome (payment amount, denial reason, etc.) Please check if this is the first time you are asking for a review of the claim.
- ☐ Claim Dispute: You disagree with the outcome of the Request for Reconsideration.

<table>
<thead>
<tr>
<th>Provider Name*</th>
<th>Provider Tax ID*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider NPI*</td>
<td>Date of Last Explanation of Payment</td>
</tr>
<tr>
<td>Allwell from Absolute Total Care Claim Number*</td>
<td>Date of Service*</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member ID</td>
</tr>
</tbody>
</table>

* Indicates a required field

Reason for the reconsideration/dispute (please check all that apply):
- ☐ Claim was denied for no authorization, but authorization number was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for member not being eligible, but member was eligible on date of service (attach eligibility information.)
- ☐ Claim was not paid per the terms of my contract with Allwell from Absolute Total Care (attach relevant reimbursement section.)
- ☐ Claim was denied “Past Timely Filing” (attach proof of timely filing.)
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information.
- ☐ Other: Please explain:

________________________________________________________

Please ensure sufficient detail is provided to assist us in the review of your reconsideration or dispute. A copy of the Explanation of Payment (EOP) and supporting documentation must be submitted with the request. *Non-contracted providers must also submit a completed and signed Waiver of Liability (WOL), a copy of which may be found on our website at allwell.absolutetotalcare.com.

Mail completed forms and all attachments to:

Allwell from Absolute Total Care
Medicare Grievance & Appeals Department
P.O. Box 3060
Farmington, Missouri 63640-3800

Contact Name and Number of Person Requesting the Appeal: ________________________________

PRV2018 02 ProviderReconsiderForm_Approved_01222019