Reimbursement Reconsideration Submission Form

Member information

Member first/last name: _____ Member date of birth: _____

Member ID: _____

Provider/provider representative information

Provider first/last name: _____ NPI number: _____

Provider street address: _____

City: _____ State: _____ ZIP code: _____

☐ I am a participating provider. ☐ I am a nonparticipating provider.

Provider representative: ☐ Self ☐ Billing agency ☐ Law firm ☐ Other: _____

Representative contact name: _____ Contact phone: (_____) _____

Representative street address: _____ Email: _____

City: _____ State: _____ ZIP code: _____

Claim information*

Claim number: _____ Billed amount: $_____ Amount received: $_____

Start date of service: _____ End date of service: _____ Authorization number: _____

***** For multiple claims related to the same issue, providers can use one form and attach a listing of the claims with each supporting document.

Reimbursement reconsideration

Amerigroup Kansas, Inc. encourages providers to use our reconsideration process to dispute claim determinations. The reconsideration process is optional and is a way for providers to request review of a claim payment without exercising the formal appeal process. We accept verbal, web and written claims reconsiderations within 120 calendar days (123 days if mailed) of the date on the *Explanation of Payment (EOP)*. A reconsideration resulting in an adjustment to the claim payment results in the issuance of an *EOP* reflecting the adjustment.

Providers will receive a *Reconsideration Determination* letter. If providers disagree with the reconsideration determination, they have an additional 60 calendar days (63 days if mailed) from the date of the determination letter to file a payment appeal.

If providers elect not to file a reconsideration, the appeal must be filed within 60 days (63 days if mailed) of the *EOP*, and all appeals must be received either via web or in writing. If bypassing the reconsideration process or if appealing a reconsideration determination, please refer to the *Claim Payment Appeal Form* for submission of an appeal. Do not submit the *Reconsideration Request Form* for a formal appeal.

To ensure timely and accurate processing of your request, please check the applicable determination provided by Amerigroup on the *EOP*.

☐ Untimely filing
☐ No authorization
☐ Denied for other health insurance (OHI), but member doesn't have OHI
☐ Experimental/investigational procedure denial
☐ Claim code editing denial
☐ Retrospective authorization issue
☐ Disagree that you were paid according to your contract
☐ Data elements on the claim on file does not match the claim originally submitted
☐ Denied as duplicate
☐ Denial related to provider data issue
☐ Member retro-eligibility issue
☐ ER level of payment review
☐ Other:_____

If submitting in writing, please mail this form, a listing of claims (if applicable) and supporting documentation to the following address or attach and submit through our provider website:

Reimbursement Reconsideration
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599
https://providers.amerigroup.com/KS