

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: _____ |
| <input type="checkbox"/> I am a participating provider. <input type="checkbox"/> I am a nonparticipating provider. | |
| Provider representative: <input type="checkbox"/> Self <input type="checkbox"/> Billing agency <input type="checkbox"/> Law firm <input type="checkbox"/> 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 the determination letter was mailed to file a payment appeal. Providers may include testimony in addition to evidence and legal and factual arguments when submitting reconsiderations or appeals. Providers may also have their case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Amerigroup in connection with the reconsideration or 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 on the *EOP*.

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