

## **REQUEST FOR CLAIM RECONSIDERATION**

PG:	
Log#:	

This form and accompanying documentation <u>MUST</u> be submitted 60 days from the date on the Explanation of Payment (EOP). Retain a copy of reconsideration for your records. RECONSIDERATIONS SUBMITTED WITHOUT ALL OF THE NECESSARY DOCUMENTATION AND/OR AFTER THE 60-DAY LIMIT HAS EXPIRED, ARE NOT ELIGIBLE FOR RECONSIDERATION AND THE HEALTH PLAN WILL RETURN FORM TO PROVIDER'S OFFICE.

PROVIDER NAME: DATE PREPARED:  TAX ID: PERSON COMPLETING FOR			DATE PREPARED:		
			RSON COMPLETING FORM	М:	
HEALTH PLAN PROVIDER #:		TE	TELEPHONE #:		
	e claims, please check here:  e claim, please complete the membe	r information and claim fields	below:		
MEMBER NAME:		DOS:		CLAIM #:	
MEMBER ID #:		PATIENT ACCO	PATIENT ACCOUNT #:		
Provider Comments:			REASON FOR CONSIDERATION (please check⊠):  ☐ COB: Attach a copy of the primary payer's EOP		
			DENIAL – No Precertifica	tion: Attach medical documentation	
			DENIAL – Claim Edit: Atta	ach medical documentation (only 1 claim per form)	
			DENIAL - OTHER:		
			RETRACTION OF PAYME	ENT:	
			Date of Service	Procedure Code(s)	
			CORRECTION: Attach a corrected claim form		
			Identify Data Change		
			DISPUTE - Incorrect paym	nent or denial: Attach supporting documentation	
SUBMIT TO:  Number of Pages:  HPPNM17 P:/Pub/Provnet/PCOC/Forms	Claims Department Geisinger Health Plan PO Box 8200 Danville, PA 17822	HEALTH PLAN USE ONLY:  Approved: Reconsideration reported on EOP within 45 days of receipt.  Reconsideration denied. Explanation:			