1900 North Loop West Suite 400 Houston, Tx 77018
Phone: (832)320-7220 Fax:(832)320-7221

Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

NOTE

- **Please submit a separate Claim Reconsideration Request form for each request.**
- **No new claims should be submitted with this form.**
- **Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.**

Please refer to the attached Claim Reconsideration Reference Guide, your provider administrative manual or our provider website for additional details including where to send paper Claim Reconsideration Requests. You may verify the member's address using the eligibility search function on the website listed on the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, Durable Medical Equipment (DME), etc.)

Member information **Date form completed** _____

Member ID	Control / Claim #	Date of Service	Billed Amount
Member Last Name		First Name	I
Street Address		City	State Zip
Patient: Last Name		First Name	I

Physician/Health care professional information

Tax Identification Number (TIN):_____ Phone Number (with area code): _____

Email Address: _____

Physician or other Health Care Professional Name(as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB)

Last Name First MI

Street Address City State Zip

Facility/Group Name_____ Contact Person _____

Expected amount owed _____ Contact Fax Number (with area code) _____

Reason for request: ***(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration Request definition sheet on Integranethealth.com)***

☐ 1. Previously denied / closed as "Exceeds Filing Time"
☐ 2. Previously denied / closed for "Additional Information"
☐ *3.* Previously denied / closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
☐ 6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of a claim with "Bundled" services
☐ 8. Medical Records Submission
☐ 9. Other *(explain below)*

Please include what you are expecting from IntegraNet Health regarding this Claim Reconsideration Request to close this out in your practice management system, including dollar amount if possible.

Comments

Required attachments
• Copy of PRA or EOB
• Claim Form is **ONLY** required for Corrected Claims Submissions
• Other required attachments as listed above

You may have additional rights under individual state laws. Please review the provider website, your provider administrative guide or your provider agreement/contract if you need more information.