

HOSPITAL CLAIM RECONSIDERATION REQUEST FORM

Please print clearly in blue or black ink. You must complete a separate form for each claim.

Member's full name		Member ID #	
Patient's full name		Patient's date of birth	
Claim number		Original claim: <input type="checkbox"/> Paper <input type="checkbox"/> Electronic	
ICD-10 code	CPT code	HCCPS code	DRG code
Rendering facility/group name			
Provider's Tax ID # (TIN)		Provider's National Provider Identifier # (NPI)	
Amount billed		Amount paid	
Date(s) of service		Date paid	

NOTE: This form should not be used for routine claim status requests. Please check your claim status by calling our Interactive Voice Response system at (888) 819-1199 or by using NaviNet through the "For Providers" tab at www.1199SEIUBenefits.org.

REASON FOR RECONSIDERATION REQUEST

Please explain why you are filing this request (check all that apply):

- | | |
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| <input type="checkbox"/> Claim was previously denied as "Exceeds Timely Filing."
(<i>Attach proof of timely filing</i>) | <input type="checkbox"/> Claim was previously processed with an incorrect contracted rate.
(<i>Explain under "Other"</i>) |
| <input type="checkbox"/> Claim was previously denied with request for clarification/additional information. (<i>Attach requested documents</i>) | <input type="checkbox"/> Claim was previously processed with an incorrect Diagnosis Related Group (DRG). (<i>Attach supporting documentation</i>) |
| <input type="checkbox"/> Claim was previously denied for lack of "Coordination of Benefits" information. (<i>Attach primary insurance carrier's Explanation of Benefits</i>) | <input type="checkbox"/> Claim was previously processed with a request for revisions that follow Correct Coding Initiative (CCI) guidelines for bundling claims.
(<i>Attach supporting documentation</i>) |
| <input type="checkbox"/> Claim was previously denied for lack of authorization/medical necessity.
(<i>Attach proof of authorization/clinical documentation</i>) | <input type="checkbox"/> Other (<i>Explain below</i>) |
| <input type="checkbox"/> Claim was previously denied because 1199SEIU member was deemed ineligible for services provided, but 1199SEIU member is eligible for services. | |
| <input type="checkbox"/> Claim was previously processed with an incorrect provider Tax ID Number (TIN). (<i>Explain under "Other"</i>) | |

Hospital Claim Reconsideration Request Forms must be submitted within 180 days of the date the claim was originally denied or paid.

NOTE: This reconsideration request is NOT considered an administrative appeal under the terms of the Plan or under the regulatory provisions of the Employee Retirement Income Security Act of 1974 (ERISA appeal). An assignment of benefits does not confer an independent right to an ERISA appeal of a Plan determination. In order for a "Non-Participating Provider" to represent a patient in an ERISA appeal, the patient must sign and submit a Benefit Fund Appeal Representation Authorization Form, following the initial claim determination. All "Participating Providers" have agreed, by way of contract, that payment disputes with the Fund may only be addressed through the contractual process and do not involve the patients.