Provider Post Service Claim Reconsideration/Appeal Form

Please note the following to avoid delays in processing provider appeals and/or reconsiderations:

- **Include supporting documentation.** See CareOregon Provider Manual H7, appeal guidelines
- Submissions by Non Par Medicare provider must include a completed Waiver of Liability Statement. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf ; Appendix 7
- Submit a separate form for each claim appeal or reconsideration (i.e., one form per claim).
- Applicable filing limit standards apply.

NOTE: For corrected claim, DO NOT USE this form. Use last digit of the Bill Type for UB or Box 22 of HCFA (6-Corrected claim, 7-Replacement of prior claim)

Submit Via EDI or Mail **corrected claims** to: CareOregon Claims Department - Corrected Claims
P O Box 40328
Portland, OR 97240-9934

Step 1: Provide the following information:

Member ID: _____ **Member Name:** _____

Date of Service: _____ **Submission Date:** _____

Provider Contact Name: _____ **Provider Tel. Number:** _____

Claim Number: _____

Step 2: Determine type of request being submitted:

☐ **Reconsideration for Payment**

- Denied for missing information/documentation *not including authorization related denials*
- Duplicate claims
- Timely filing denials

☐ **Claim Appeal**

- Previously upheld reconsiderations
- Authorization related denials *other than requests for retro authorization.*
- Contract rate
- Excluded Benefits

Step 3: Mail or fax all information to:

CareOregon Claims Department
Reconsiderations/Claim Appeals
PO Box 40328
Portland OR 97240-9934

Fax to: Claim Appeals Coordinator
Fax number: **Medicaid 503-416-8115**
Medicare 503-416-1330