

Provider Claim Appeal/Reconsideration 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
- Incomplete submissions will be returned for additional information.
- Submit a separate form for each claim appeal or reconsideration (i.e., one form per claim).
- Applicable filing limit standards apply.

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:
Is this request a: <input type="checkbox"/> Reconsideration <input type="checkbox"/> Appeal

Step 3: Select one box and/or provide a letter of explanation to describe purpose of appeal.	
Appeal Type:	Required Documentation:
<input type="checkbox"/> Contract rate, payment policy or clinical policy – Incorrect contract term or rates were applied to the original claim, resulting in an over/underpayment or final claim payment was incorrect due to global reimbursement or (un) bundling of billed services.	<ul style="list-style-type: none"> • Appeal form • Original remittance advice • Supporting documentation
<input type="checkbox"/> Corrected Claim – Claim denied for incorrect member, date of service, incorrect/missing procedure/diagnosis code, incorrect count, incorrect/missing location code and modifier added/removed.	<ul style="list-style-type: none"> • Appeal form • Corrected CMS-1500 or UB 04 • Original remittance advice • Supporting documentation
<input type="checkbox"/> Duplicate claim – Claim originally denied as a duplicate claim.	<ul style="list-style-type: none"> • Appeal form • Original remittance advice • Supporting documentation
<input type="checkbox"/> Filing Limit – Claim originally denied for untimely filing.	<ul style="list-style-type: none"> • Appeal form • Original remittance advice • Supporting documentation
<input type="checkbox"/> Pre-certification/notification or prior-authorization denials – Claim originally denied for failure to notify or pre-authorize services.	<ul style="list-style-type: none"> • Appeal form • Original remittance advice • Records supporting medical necessity • Supporting documentation
<input type="checkbox"/> Response to request for additional information – Claim originally denied for additional information. <input type="checkbox"/> Primary Carrier EOB <input type="checkbox"/> Consent Form <input type="checkbox"/> ER chart notes <input type="checkbox"/> Itemization <input type="checkbox"/> Other _____	<ul style="list-style-type: none"> • Appeal form • Original remittance advice • Supporting documentation
<input type="checkbox"/> Other – _____	<ul style="list-style-type: none"> • Appeal form • Original remittance advice • Supporting documentation

Step 4: Mail or fax all information to:	
CareOregon Claims Department Appeals PO Box 40328 Portland OR 97240-9934	Fax to: Claim Appeals Coordinator Fax Number: 503-416-8112