Provider Post Service Claim Reconsideration/Appeal Form

Submit a separate form for each claim appeal or reconsideration (i.e., one form per claim).
Applicable filing limit standards apply.

Provide the following information:

Today's Date: _____

Member ID: _____ Date of Service: _____
Member Name: _____ Provider Contact Name: _____
Claim Number: _____ Provider Phone Number: _____

Please Note: OHP denials for being out of network will not be reconsidered and Post Service Claim Reconsiderations/ Appeal forms will be closed without review.

Select type of request - If the missing information is related to an auth denial this is considered an **Appeal**. If the provider did not get an auth then it is considered a **Retro auth request**.)

☐ Reconsideration for Payment – Supporting documentation MUST BE attached.

- Retro Enrollment Updates
- Overpayment Errors
- Timely filing denials
- Denied for missing information/documentation
  - Itemized Bills or Chart notes
  - Primary EOB
  - Consent Forms (missing, incomplete or corrected)

☐ Retro Auth Request - Supporting documentation MUST BE attached (reason why prior auth not requested)

- Auth Issue - Denied No Auth

☐ Claim Appeal – please check one if known

- ☐ Auth Issue - Denied at time of authorization
  - Requires additional information
- ☐ Auth Issue - Denied Inconsistent with Auth
- ☐ Auth Issue - Denied Authorization Units Exceeded
- ☐ Auth Issue - Dental
- ☐ Auth Issue - DME, HH, EPIV, Limb Prosthetics
- ☐ Auth Issue - Pharmacy
- ☐ Payment Dispute - Contract Rate
- ☐ Payment Dispute - Duplicate
- ☐ Payment Dispute - Enrollment Issue
- ☐ Payment Dispute - Not covered/Excluded
- ☐ Payment Dispute - Sterilization Consent
- ☐ Payment Dispute - COB/EOB – OIC
- ☐ Other _____

NOTE: Submissions by **Non Par Medicare providers** must include a completed Waiver of Liability Statement. The model waiver of liability notice is available in both Microsoft Word and PDF formats from the CMS website: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html

Corrected Claims - DO NOT USE this form. Use last digit of the Bill Type for UB 6-Corrected claim, 7-Replacement of prior claim or Box 22 of HCFA and resubmit your claim via EDI or Mail.

Fax or mail all information to:

Fax to: Claim Appeals Coordinator Fax number: **Medicaid 503-416-8115** **Medicare 503-416-1330**	**CareOregon Claims Department** Reconsiderations/Claim Appeals PO Box 40328 Portland OR 97240-9934