Claim Reconsideration Form

Instructions: This form is to be completed by providers to request a claim reconsideration for members enrolled in a plan managed by CareCentrix.

Mail address: Send all Claim Reconsideration requests to

CareCentrix
Claim Reconsideration
111 Founders Plaza, Suite 801
East Hartford, CT 06108

No new claims should be submitted with this form. Please submit a separate form for each claim.

Patient Information

Name	**DOB**	**Intake ID**	
Address: Street		**State**	**Zip Code**

Provider Information

Name	**TIN**	**NPI**	
Address: Street		**State**	**Zip Code**

Claim Information

Provider Invoice Number	**Service "From/To" Date**	**Original Amount Billed**
HCPCS/CPT and Modifiers Billed		**Original Amount Paid**
Claim Number	**Authorization Number(s)**	

Reason For Reconsideration Request

___ Claim denied for timely filing
___ Claim denied for Time In/Time Out or Oasis
___ Claim denied for primary payer's payment/denial information
___ Resubmission of a corrected claim (explain correction below)
___ Claim underpaid
___ Other

Please be specific when completing the description of dispute and the expected outcome, including dollar amount if possible.

Comments:

Contact Name:_____ Date:_____