**Please submit the completed form and attachments via the website at: https://prohcn.com/claims**

# PROVIDER CLAIM RECONSIDERATION REQUEST FORM

This form should be used if you would like a claim reconsidered. This is not a formal appeal. Requests must be submitted within 365 days of the date of service. If the request is filed after the 365-day timeframe, please include your reason for not making this request earlier.

- ✓ **Please complete one request form for each claim you are submitting for reconsideration.**
- ✓ **Please include HoldHarmless Waiver with this form.**

## The following criteria MUST be completed

### Beneficiary Information

| | | |
|---|---|---|
| Beneficiary Name | | Date of Birth |
| Address | | |
| City | State | Zip Code |

### Claim Information

| | | |
|---|---|---|
| Member ID Number | Original Claim Number | Authorization Number |
| Date of Service | CPT/HCPCS Code | |

### Home Care Provider Information

| | | |
|---|---|---|
| Name of Claimant or Representative | Provider TIN | Provider NPI |
| Address | | |
| City | State | Zip Code |

## Request for clerical error reconsideration

| Reason for Reconsideration | Originally submitted as | Date of original submission | Correction |
|---|---|---|---|
| Not a true duplicate | | | |
| Modifier omitted or submitted incorrectly | | | |
| Quantity billed submitted incorrectly | | | |
| Billed amount submitted incorrectly | | | |
| Other | | | |

## Redetermination Request: Dissatisfaction with the original claim determination

The reason I disagree with the initial determination is:

- ☐ The service was denied as a duplicate incorrectly
- ☐ The service was not overutilized
- ☐ Other
- ☐ Additional Information:

# WAIVER OF LIABILITY STATEMENT

Claim #:

| Enrollee's Name: | Member ID: |
|---|---|
| Provider: | Dates of Service: |
| Health Plan: | |

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that thesigning of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

| Signature: | Date: |
|---|---|