Please submit the completed form and attachments via the website at: https://tangocare.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.

- ✓ **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 NPT
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 CPR 422.600.

Signature:	Date: