

**Provider Correspondence
Claim Reconsideration Request Form**



If you received a letter from Claim Management Services, Inc. (CMSi) requesting additional information, please do not use this form. Return the original letter with all information requested to us.

Use this form for situations where you disagree with a denial or payment and/or to submit a corrected claim. Mail the completed form to:

Claim Management Services, Inc.
975 Hansen Road
PO Box 10888
Green Bay, WI, 54307-0888

New claims should not be submitted with this form.

Date form completed: _____

SUBSCRIBER INFORMATION

Subscriber ID # (Including alpha prefix): _____

Subscriber's Name (last, first, middle initial): _____

Patient's Name (last, first, middle initial): _____

Claim #: _____ DOS: _____ Total Claim Billed Amount: _____

HEALTH CARE PROVIDER INFORMATION

Billing Provider ID #: _____

Billing Provider Name: _____

Rendering Provider ID #: _____

Rendering Provider Name: _____

Contact Person Name: _____ Phone #: _____

REASON FOR REQUEST

- 1. Denied for "Untimely Filing" (attach valid proof of timely filing, computer generated activity report or print screen, EOB statement or letter from another insurance carrier which may prove claims were filed timely.)
- 2. Denied for "Coordination of Benefits" (attach primary carrier's Explanation of Benefits)
- 3. Resubmission of a corrected claim (attach corrected claim and medical records and explain below)
- 4. Claim not processed at contracted rate (explain below)
- 5. Denial for no referral, pre-certification, prior authorization (attach proof)
- 6. Bundled charges (attach supporting documentation [i.e. medical records] and explain below)
- 7. Other (explain below)

Comments: _____

Required attachments:

- Copy of Provider Remittance Advice (PRA) or Explanation of Benefits (EOB)
- Claim form (**corrected** claim resubmissions **ONLY**)
- Other required attachments as listed above