January 3, 2023

Dear Providers,

Thank you for your continued partnership with SilverSummit Healthplan. As you know, we continually review and update our forms to ensure that they are designed to comply with industry standards.

Effective January 1,2023, providers will now have the ability to submit a Reconsideration Request form or a Claim Appeal Form when a provider has a question or is not satisfied with the information, they have received related to a claim outcome. Our provider partners will still be able to utilize our current form until March 31, 2023.

Please Refer to your Provider Manual for details on your appeal rights. The required Provider Reconsideration form and the Claim Appeal Form can be found on the next page, along with our quick reference guide for claims, reconsiderations, and appeals.

Thank you,

SilverSummit Healthplan

Required Reconsideration Request Form

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Provide additional information to support the description of the dispute.
Do not include a copy of a claim that was previously processed.

Reason for the reconsideration (please check all that apply):

- Sterilization consent form
- Primary insurance EOP
- Invoice
- Itemized bill (inpatient hospital claims or as requested)
- Unlisted procedure code documentation
- Medical records related to a claim denial (NOT related to a medical necessity appeal)
- Claim was denied for no authorization, but authorization number was obtained.
- Claim was denied due to lack of Nevada Provider Medicaid enrollment. The IPN is:
- Claim was not paid per the terms of my contract with SilverSummit HealthPlan.
- Please explain and advise of your payment expectation/amount:
- Other, please explain :

Note: No form is required for the submission of corrected claims.
For corrected claims, please use the claims resubmission process outlined in the provider manual.

Provider Name:

Provider TIN Number:

Medicaid Provider Number:

Provider Contact Number:

Contact Name:

Contact Address:

Member Name:

Members Medicaid Number:

Date(s) of Service:

Claim Number(s):

Medicaid Remittance Date:

Billed Charge(s):

MAIL COMPLETED FORMS AND ALL ATTACHMENTS TO:

SilverSummit Healthplan
PO Box 5090
Farmington, MO 63640-5090

SilverSummit Healthplan will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you an updated EOP with the denial reasoning). If we overturn our original decision, we will send you an updated EOP stating our decision and any additional payment due will appear on the provider remittance. This form may be photocopied.

Required Claim Appeal Form

**DO NOT USE THIS FORM FOR A RECONSIDERATION REQUEST.
USE THE "RECONSIDERATION REQUEST FORM".**

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal. Any appeal request received with an incomplete form and/or missing documentation cannot be reviewed and will be returned to you for completion.

Provider Name:

Provider TIN Number:

Medicaid Provider Number:

Provider Contact Number:

Contact Name:

Contact Address:

Member Name:

Members Medicaid Number:

Date(s) of Service:

Claim Number(s):

Medicaid Remittance Date:

Billed Charge(s):

Reason for the reconsideration (please check all that apply):

- Claim was denied for no authorization, but authorization number was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for no authorization; however, authorization was not obtained due to member's eligibility or medical condition.
- Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- Claim was not paid per the terms of my contract with SilverSummit HealthPlan (attach relevant reimbursement section).
- Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- Claim was denied "Past Timely Filing" (attach proof of timely filing).
- Claim was paid the incorrect amount (include calculation of expected payment and supporting information)
- Claim denied based on SilverSummit HealthPlan's payment policy (attach medical records to support services provided). Note: Payment policies can be found at https://www.silversummithealthplan.com/providers/resources/COPY_clinical-payment- policies.html
- Other. Please explain (and provide supporting documentation):

MAIL COMPLETED FORMS AND ALL ATTACHMENTS TO:

**SilverSummit Healthplan
PO Box 5090
Farmington, MO 63640-5090**

SilverSummit Healthplan will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision or overturn out original decision). If we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance. This form may be photocopied

silversummit healthplan

Quick Reference Guide for Claims, Reconsiderations, and Appeals

Name	Description	Submission Information
Corrected Claim	A corrected claim is when a provider needs to make a correction to the original claim submission	A Corrected Claim can be submitted via the website at website or in writing to SilverSummit Healthplan Attn: Corrected Claim, PO Box 5090 Farmington MO 63640-5090. The claim must include the original claim number in field 22 of a CMS 1500 or field 64 of the UB04. Failure to include the original claim number and frequency code may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.
Claim Reconsideration	Submitted when a provider disagrees with how a clean or adjusted claim was processed. Examples include but are not limited to: • Denials related to code edits or authorization. Requests related to code edit or authorization denial require medical records and must accompany the request for reconsideration. • Payment amount which does not align with expected payment.	Submitters have 60 days from the from the date of the Medicaid Remittance to file request for reconsideration via EDI, through the Secure Provider Portal found on our website at https://provider.silversummithealthplan.com, or by mail to the address below. Requests submitted by mail must include a completed Provider Claim Reconsideration Form, which can be found on the Provider Forms page of our website, as well as supporting documentation. SilverSummit Healthplan Attn: Claims Department P.O. Box 5090 Farmington, MO 63640-5090
Claim Appeal	Submitted when a provider has received an unsatisfactory response to a previous reconsideration request. • Any adverse action, including the denial or reduction of claims for services included on a clean claim. • Providers may also dispute SilverSummit HealthPlan's policies, procedures, rates, contract disputes, and any aspects of SilverSummit HealthPlan's administrative functions	Submitters have 60 days from the from the date of the Medicaid Remittance to file request for claim payment appeal. Claim appeals must be submitted in writing to the address below and must include the required Provider Claim Appeal form completed in its entirety, which can be found on the Provider Forms page of our website, along with the appropriate appeal documentation and can be submitted to SilverSummit Healthplan Attn: Appeals & Grievances P.O. Box 5090 Farmington, MO 63640-5090