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