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.