# *Required* Reconsideration/Appeal Form

Use this form as part of SilverSummit Healthplan reconsideration/appeal process to address the decision made during the request for review process. This form should be utilized if a claim has been processed and a Medicaid Remittance Advice issued from SilverSummit Healthplan. Do not use for first time claims or corrected claims. For corrected claims, please use the claims resubmission process outlined in the provider manual.

All claim requests for reconsideration or claim disputes must be received within **60 calendar days** from the date of the Medicaid Remittance. All fields below are required information. Failure to complete the form may result in a delay of your request.

A Reconsideration is a request for SilverSummit Healthplan review a claim with additional information submitted by the provider that was not previously submitted. Supporting documentation for review include, but is not limited to:

- Copy of Invoice for Pricing Review
- Additional documentation which would clarify services

An Appeal is a formal written request to SilverSummit Healthplan for reconsideration of a medical or contractual adverse decision. Types of claim denials that would be an appeal include but are not limited to:

- Precertification
- Experimental/Investigational
- Not Medically Necessary

| Members Name: | Members Medicaid Number: |
|---|---|
| Date(s) of Service: | Control/Claim Number(s): |
| Medicaid Remittance Date: | Billed Charge(s): |
| Provider Name: | Provider TIN Number: |
| Medicaid Provider Number: | Provider Contact Number: |
| Contact Name: | Contact Address: |

Please check the appropriate box below.

q **RECONSIDERATION: The attached claim(s) was originally submitted with incorrect/insufficient information.**

q **APPEAL: Must include medical records or medical information.**

Please include relevant claim information and any supporting medical or clinical documentation with this form and mail to the following address:

**SilverSummit Healthplan**
**P.O. 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