CLAIM RECONSIDERATION FORM

Use this form as part of the PA Health & Wellness Claim Reconsideration process to dispute the decision made during the request for reconsideration process.

NOTE: All claim requests for reconsideration, corrected claims or claim disputes must be received within 365 calendar days from the date of service.

All fields in the box immediately below are required information

Provider Name	Provider Tax ID#
Claim/Control Number *Located EOP Under Patient Name*	Date(s) of Service
Member Name	Member (ID) Number
Reconsideration Request Reason	

Date of Request: _____ _____ Requestor Name: _____

Requestor Phone Number: _____

ATTACH: A Copy of the EOP(s) with Claim(s) to be reconsidered.

Mail completed form(s) and attachments to:

PA Health & Wellness
Attn: Reconsideration
PO Box 5070
Farmington, MO 63640

PA Health & Wellness will make reasonable efforts to resolve all requests within 30 calendar days of receipt. Based upon the information submitted, they will either uphold the original decision, or overturn the original decision. If the original decision is upheld, you will be sent a letter stating the reason(s) for the decision. If the original decision is overturned, you will receive a letter stating PA Health & Wellness' decision and any additional payment due will appear on your remittance.

NOTE: If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the provider manual. Please do not include this form with a corrected claim.

(This form may be photocopied)