Sanford Health Plan, Attention: Appeals
PO Box 91110, Sioux Falls, SD 57109-1110
Fax: (605) 312-8217

# Provider Claim Reconsideration Request

**To Submit a Claim Reconsideration Request:** Provide the information shown below and complete a separate request for each claim. Return with the associated Explanation of Payment (EOP) and/or supporting documentation via the link on Provider Portal for Medicare Advantage.

**Please note:**

- This form is to be used for Medicare Advantage and I-SNP products only.

## INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED

| Provider Information | |
|---|---|
| Provider Name: | Contact Name: |
| NPI Number: | Phone Number: |
| Fax Number: | Email Address: |
| Contact Address: | |

| Member/Claim Information | |
|---|---|
| Member Name: | Date of Birth: |
| Member ID Number: | Date(s) of Service: |
| Claim Number(s): | |

**Type of Reconsideration Request**

☐ **Duplicate Claim:** A first time claim submission that denied as a duplicate filing, or the service lines on the claim were denied as a duplicate.

**Required Documentation:** Original EOP

☐ **Code Review:** The provider feels the denied claim was coded correctly.

**Required Documentation:** Provide explanation/rationale below.

## Type of Reconsideration Request (continued)

☐ **Timely Filing:** A first time claim submission that denied for timely filing. Timely filing is the number of days shown below from the date of service, date of inpatient discharge or paid date on the primary EOP:
- 180 days for participating providers
- 365 days for non-participating providers and any provider who cares for North Dakota Medicaid Expansion Members

**Required Documentation:** Screen-print from the billing system showing the date the claim was sent to Sanford Health Plan. If filed electronically, the name of the clearinghouse used with evidence the claim was accepted by the Plan without error must also be included.

☐ **Request for Additional Information:** A first time claim submission that denied for additional information, due to an unlisted/unspecified procedure code that was submitted without supporting documentation or a procedure code that was not submitted with operative or anesthesia notes, a pathology report, and/or office notes.

**Required Documentation:** Provide explanation/rationale below and relevant clinical documentation.

☐ **Other:** Network, Scope of practice, experimental /investigational denials or other to request a claim reconsideration for topics not mentioned above.

**Required documentation:** Provide explanation/rationale in the comments below.

**Comments:**

## Please do not use this form for the following requests:

- Authorizations
- Corrected Claim
- Coordination of Benefits
- Incorrect Reimbursement

**For questions on the above requests please contact :**

- (888) 278-6485 TTY: (888) 279-1549 (Align powered by Sanford Health Plan) or
- (844) 637-4760 TTY: (888) 279-1549 (Great Plains Medicare Advantage)

## Signature

| Signature of Person Requesting Reconsideration | Today's Date |
|---|---|
| | |