Sanford Health Plan, Attention: Appeals
PO Box 91110, Sioux Falls, SD 57109-1110
Phone: (800) 601-5086 Fax: (605) 312-8910

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 Provider Portal, fax (605) 312-8910 or mail.

Please note:

- **Effective 8/1/21** we will be requesting that provider reconsideration(s) requests be sent via our portal on sanfordhealthplan.com. For instructions on how to request this access to the portal, please email providerrelations@sanfordhealth.org.
- **After 10/1/2021** documents will not be processed or receive a response.

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:

***You do not use this form for the following requests:**

- **Retrospective Authorization Request** – Please submit through the provider portal if the services is on the Prior Authorization list. You have 60 days from date of service for submission.
- **Corrected Claim**- Resubmit the claim electronically or fax to **(605) 328-6840.**
- **Coordination of Benefits-** Fax the other carrier's EOB/EOP to **(605) 328-6840.**
- **Incorrect Reimbursement-** Fax to Provider Relations at **(605) 328-7224**.
- **MultiPlan or Data iSight Reimbursement-** Call MultiPlan at (800) 950-7040 or Data iSight at (866) 835-4022 to file a reimbursement appeal.

Signature

Signature of Person Requesting Reconsideration	Today's Date