Sanford Health Plan, Attention: Appeals
PO Box 91110, Sioux Falls, SD 57109-1110
Phone: (877) 652-8544 Fax: (605) 312-8910

SANFORD HEALTH PLAN

Provider Claim Reconsideration Form

Instructions: Complete all information and submit with the associated Explanation of Payment (EOP) in addition to supporting documentation as outlined below by mail, fax or via the Provider Portal.

Physicians, hospitals or other health care professionals should submit a separate Claim Reconsideration Form for each request. For a Member appeal or dispute, the Member must complete a Member Appeal Form.

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):	
Review Type (Check one box to reflect purpose of request.)	
☐ **Duplicate Claim:** A first time claim submission that denied for, or is expected to deny for duplicate filing, or the original claim or service lines within a claim was denied as a duplicate. Documentation: original EOP	
☐ **Code Review:** The previously processed claim was coded incorrectly. Documentation: explain rationale below.	
☐ **Timely Filing:** A first time claim submission that denied for, or is expected to deny for untimely filing. Timely filing is 180 days from the date of service, discharge for inpatient services, or from the paid date on the primary EOP for participating providers. Non-participating providers and those providing services to North Dakota Medicaid Expansion Members have 365 days. Documentation: screen-print from the billing system showing the date the claim was sent to the Plan. If filed electronically, the name of the clearinghouse being used with evidence the claim was accepted by the Plan without error must also be included.	
☐ **Clinical Payer Policy:** The previously processed claim was incorrectly reimbursed because of the associated Sanford Health Plan clinical policy. Documentation: explain rationale below.	
☐ **Payment Payer Policy:** Provider believes that the final claim payment was incorrectly reimbursed because of Sanford Health Plan's payment policy (assistant surgeon, global/package billing, bundled services) or un-bundling of billed services (claim editing software). Documentation: Date of delivery for global OB claims, code(s) and clinical documentation for assistant surgeon reconsiderations.	
☐ **Lack of Preauthorization:** Claim was denied due to failure to preauthorize. Documentation: clinical documentation.	
☐ **Request for Additional Information:** A first time claim submission that denied for additional information, an unlisted procedure code was submitted without supporting documentation or a procedure code was denied or not submitted with operative notes, anesthesia notes, pathology report, and/or office notes. Documentation: explain rationale below and/or clinical documentation.	
☐ **Corrected, Voided or Overpayment of Claim:** The previously paid or denied claim requires an attribute correction (e.g., incorrect Member, ID number, incorrect date of service, incorrect or missing procedure or diagnosis code, location code, incorrect amount, or modifier added or removed. Corrected claims must be resubmitted through your clearinghouse (electronically), via fax or mail to the Claims Department. For claim status inquiries, contact Customer Service. For instructions on resubmission of electronic corrected claims, see the Provider Manual. Documentation: none/corrected claim.	
☐ **Coordination of Benefits:** The requested review is for a claim that was denied or could not fully be processed until information from another insurer has been received or a reply to a request for other insurance information. Documentation: EOB/EOP from other payer.	
☐ **Contract term(s):** Belief that processed claim was not paid in accordance with Provider Manual, contract terms or rates resulting in either an under or overpayment. This may include fee schedules, negotiated rates, Ambulatory Payment Classification (APC) Payments. Documentation: explain rationale below.	
Comments:	

Signature of Person Requesting Reconsideration Today's Date