Sanford Health Plan, Attention: Appeals
PO Box 91110, Sioux Falls, SD 57109-1110
Phone: (800) 601-5086 Fax: (605) 328-7224

SANFORD HEALTH PLAN

Provider Claim Reconsideration Request

INSTRUCTIONS:

☐ **Incorrect Reimbursement-** Fax OCE edits or code updates with supporting clinical documentation and/or rationale to Provider Relations at (800) 601-5086. Assistant surgeon reimbursement is not eligible for reconsideration; see PR-035 Assistant at Surgery Reimbursement Policy in the Provider Portal for more information.

☐ **MultiPlan or Data iSight Reimbursement**- call MultiPlan at (800) 950-7040 or Data iSight at (866) 835-4022 to file a reimbursement appeal.

☐ **Lack of Prior Authorization-** complete a Medical or Pharmacy Prior Authorization Form, notate as a RETRO request and return with supporting clinical documentation. If a denied prior authorization request is already on file, complete a Member Appeal Form.

☐ **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.

To Submit a Claim Reconsideration Request: Complete a Claim Reconsideration Request for each claim and provide the information shown below. Return with the associated Explanation of Payment (EOP) and supporting documentation via mail, fax or submit via the Provider Portal. **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.

☐ **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.

Comments:

Signature of Person Requesting Reconsideration Today's Date