



## Health Partners Plans

### Request for Claim Reconsideration

Please complete this form and include all supporting documents (up to 25 claims). Incomplete submissions **will not** be accepted. For submissions with more than 25 claims, please submit another form with all supporting documents.

If you have questions, contact Health Partners Plans at **1-888-991-9023**.

Please send a completed form and all documents to:

**Health Partners Plans  
Attn: Claims Reconsideration  
PO Box 1220  
Philadelphia, PA 19105-1220**

Date:	<b>HEALTH PLAN:</b> Health Partners Plans
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#### PROVIDER INFORMATION

Name (Last, First):	Contact Name:
Tax ID:	Phone:
NPI:	Email:

#### MEMBER INFORMATION

Note: If submitting more than one claim with the same member information, complete only one time.

Member Name (Last, First):	Member ID:
Claim Number:	Date(s) of Service:
Number of Claims:	Remark Code:

**REVIEW TYPE:** Please note the reason for your appeal.

- |  |   |
|--|---|
| <input type="checkbox"/> Claim/service denied as unauthorized                            | <input type="checkbox"/> TPL updated                            |
| <input type="checkbox"/> Claim/service denied or, paid as non-par                        | <input type="checkbox"/> Additional lines added                 |
| <input type="checkbox"/> Claim not paying according to contract                          | <input type="checkbox"/> DRG review, no medical records needed  |
| <input type="checkbox"/> Claim/service denied as duplicate in error                      | <input type="checkbox"/> NDC code added                         |
| <input type="checkbox"/> Fee schedule updated  | <input type="checkbox"/> Implants/devices invoice attached      |
| <input type="checkbox"/> Inpatient admission denied, outpatient corrected claim attached | <input type="checkbox"/> Primary EOP attached                   |
| <input type="checkbox"/> Service code/modifier corrected                                 | <input type="checkbox"/> Itemized bill for denied days attached |
| <input type="checkbox"/> Other: _____  |   |