Generations Healthcare HMO
Medicare Advantage Health Plans

Generations Claim Reconsideration Request Form

Instructions: This form is to be completed by – contracted physicians, hospitals, or other healthcare professionals to request a claim reconsideration for members enrolled in a Medicare benefit plan administered by Generations.

Mailing Address: PO Box 1747 OKC, OK 73101 Attn: Claim Reconsiderations

Physician ___ Hospital___ Other health care professional (Lab, DME, etc.)___ Date form Completed: ______________

Please submit a separate request for each claim denial. No new claims should be submitted with this form.

Member Information

Member ID: __________________ Claim # __________ Date of Service: __________ Billed Charges: __________

Member Name: ___________________ Member Date of Birth: ______________

Patient Name (if different from above): ___________________ Patient Date of Birth: ______________

Physician/health care professional information

Physician Name (as listed on the claim and/or EOB): __________________________

Billing Tax Identification Number (TIN) __________ Email: __________________________

Contact Name: _________________________ Phone: __________ Fax: __________

Reason for Request

Please include or attach any information that might be helpful in making a final claim determination.

☐ 1. Previously denied as not timely filed (Attach proof of timely evidence)
   o Electronic claims – confirmation that Generations or one of its affiliates received and accepted your claim.
   o Paper claims – a copy of screen print from your accounting software to show the date you submitted the claim.
     ▪ Include proof that claim is for the correct patient and the correct visit.
     ▪ Other insurance carrier’s denial/rejection, EOB, letter indicating termed coverage, etc.

☐ 2. Previously denied/ for additional information or inappropriate billing (provide description and/or requested documents)

☐ 3. Previously denied pending receipt of Primary insurance carrier EOB (attach copy of primary EOB)

☐ 4. Resubmission of corrected claim (explain correction below)

☐ 5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment (explain below)

☐ 6. Previously denied for no authorization (explain details below – medical necessity does not supersede contract language that indicates prior notification is required)

☐ 7. Other (Please Explain)

__________________________________________________________________________________________________
__________________________________________________________________________________________________

A final determination will be made within 45 days of receipt, unless additional documentation is required. We will notify you within 30 days if additional information is needed.