Provider Reconsideration Form

Instructions: This form is to be completed by – contracted physicians, hospitals, or other healthcare professionals to request a claim review for members enrolled in a Commercial benefit plans administered by GlobalHealth.

Mailing Address: PO Box 2328 OKC, OK 73101  Attn: Provider Payment Dispute  Date: ________________

Physician: ☐  Hospital: ☐  Other (Lab, DME, etc.): ☐

Member Information

Member/Patient Name: __________________________________________ ID: __________________________
Claim #: __________________ Date of Service: __________________________ Billed $: __________________

Physician/Hospital/Health Care professional information

Vendor Name: __________________________________________ Billing Tax ID (TIN): __________________
Contact Name: __________________________________________ Phone: __________________________

Reason for Request

Corrected Claim (attached)  Underpayment  Claim Pended or Denied

☐ CPT  ☐ Per Contract  ☐ No authorization
☐ Diagnosis (ICD-9 or ICD-10)  ☐ Units  ☐ Authorization does not match
☐ Date of Service  ☐ Other  ☐ Quality or Readmission
☐ Billed charges  ☐  ☐ Billed Inappropriately
☐ DRG  ☐  ☐ Proof of Timely Filing
☐ Modifier  ☐  ☐ Primary EOB or COB information
☐ Other  ☐  ☐ Itemized billing request
☐  ☐ Medical records

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

Including but not limited to: Proof of timely evidence and or proof GlobalHealth accepted your EDI claim (277 report), (Claims rejected on the 277 do not suffice as proof of timely filing). Other insurance carrier’s denial/rejection, EOB, letter indicating termed coverage, records, itemized billing, etc.

Comments: (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.