Provider Reconsideration Form

Instructions: This form is to be completed by – contracted and non-contracted physicians, hospitals, or other healthcare professionals to request a claim review for members enrolled in an **Oklahoma State** benefit plan administered by GlobalHealth Inc.

Mailing Address: PO Box 2658 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, Inc.* **accepted** *your Electronic 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)*

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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.