PROVIDER REQUEST FOR RECONSIDERATION AND CLAIM DISPUTE FORM

Use this form as part of the Arkansas Total Care Request for Reconsideration and Claim Dispute process. All fields are required information.

Provider Name	**Provider Tax ID #**
Control/Claim Number	**Date(s) of Service**
Member Name	**Member (RID) Number**

- A **Request for Reconsideration (Level I)** is a communication from the provider about a disagreement with the manner in which a claim was processed.
- A **Claim Dispute (Level II)** should be used only when a provider has received an unsatisfactory response to a Request for Reconsideration.
- The Request for Reconsideration or Claim Dispute must be submitted within 180 days for participating providers and 90 days for non-participating providers from the date on the original EOP or denial.
- *Any photocopied, black & white, or handwritten claim forms, regardless of the submission type (first time, corrected claim, Request for Reconsideration, or Claim Dispute) will cause an upfront rejection.*
- If the original claim submitted requires a correction, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

Level of dispute (please check):

□ Level I - Request for Reconsideration (Attach medical records for code audits, code edits or authorization denials. Do not attach original claim form.)

□ Level II – Claim Dispute (Attach the following: 1) a copy of the EOP(s) with the claim numbers to be adjudicated clearly circled 2) the response to your original Request for Reconsideration. Do not attach original claim form.)

Reason for Dispute (please check):

□ Claim was denied for no authorization, but authorization # _____ was obtained

□ Claim was denied for no authorization, but no authorization is required for this service

□ Claim was denied for untimely filing in error (attach proof of timely filing)

□ Claim was denied for global/unbundled procedure (attach medical records)

□ Claim was paid to the wrong provider

□ Claim was paid for the incorrect amount

□ Other (please explain) _____

Requestor Name: _____

Requestor Phone Number:_____ **Date of Request:**_____

Mail completed form(s) and attachments to the appropriate address:

MEDICAL CLAIMS:
Arkansas Total Care
Attn: Claims
PO Box 8020
Farmington, MO 63640

VISION CLAIMS:
Arkansas Total Care
Attn: Claims
PO Box 7548
Farmington, MO 63640