

## **Claim Action Request**

### **Instructions**

- 1) Determine the reason the claim was not processed as you expected:
  - a. Review the messages on the Remittance Advice (RA) or Explanation of Payment (EOP).
  - b. Follow up with Customer Service for clarification. (Note: The payers have indicated that sometimes they can make the correction based on a phone call alone.)
  - c. Determine if the reason for the original claims processing allows the claim to be corrected. (Note: Plan policies and contractual limitations cannot be corrected.)
- 2) Be sure to fill out the form completely and attach a copy of the RA or EOP showing the original processing. If you are correcting the claim, include it with the form as well.
- 3) Mail the completed form and attachments for Colorado members to:

RMHP  
PO Box 10600  
Grand Junction, CO 81502-5600

- 4) Mail the completed form and attachments for Wyoming members to:

WINhealth Partners Medicare Plan  
PO Box 10600  
Grand Junction, CO 81502-5600  
Attention: Judi Everett

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## Claim Action Request

Date (mm/dd/yyyy): \_\_\_\_\_

Requestor Information		
Provider Name:		
Provider # or TIN:		
Office or Practice Name:		
Contact Name:		Signature:
Telephone:		
Fax:		
Address:		
City:	State:	Zip:

Claim Information	
Patient Name:	
Patient ID # or HIC*:	<i>(include prefix or suffix if applicable)</i>
Claim Number(s):	
Date(s) of Service:	
Billed Amount:	
Process Date:	

Action Requested (Include a copy of the remittance notice and a corrected claim if necessary)		
<input type="checkbox"/> -Authorization/Referral #	<input type="checkbox"/> -Billed/Allowed amount (attach copy of manufacturer's invoice)**	
<input type="checkbox"/> -COB	<input type="checkbox"/> -Date of Service	<input type="checkbox"/> -Denied as duplicate
<input type="checkbox"/> -Diagnosis Code**	<input type="checkbox"/> -Number of units	<input type="checkbox"/> -Patient Responsibility**/***
<input type="checkbox"/> -Place of service	<input type="checkbox"/> -Procedure code/Modifier**	<input type="checkbox"/> -Other** _____
Explain:		

\* HIC = Medicare use only

\*\* May require information that substantiates your request, i.e., statement from the physician, operative report, office notes, or supporting medical documentation, etc.

\*\*\* For Medicare, include copy of ABN