

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

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"/> -Diagnosis Code**	<input type="checkbox"/> -Number of units
<input type="checkbox"/> -Place of service	<input type="checkbox"/> -Procedure code/Modifier**
	<input type="checkbox"/> -Denied as duplicate
	<input type="checkbox"/> -Patient Responsibility**/***
	<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