Banner
Health Network

January 26th, 2016

PROVIDER RECONSIDERATION REQUEST

Date_____________________________ Patient_____________________________

Health Plan_______________________ Patient ID#__________________________

Provider_________________________ Claim ID#___________________________

Provider ID#______________________ Date of Service_______________________

Please reconsider the attached claim due to:

____ Reimbursement review ____ Timely filing

____ Eligibility issue ____ Coding issue/correction

____ Authorization/Referral review ____ Other__________________________

Attached you will find: (Original/Corrected claim copy or Explanation of payment must be attached)

____ Copy of Banner EOP ____ Copy of other health plan EOP

____ Proof of timely filing ____ Operative report

____ Copy of patient ID card ____ Supporting documentation and/or notes

____ Other ____

Additional comments or explanation:

Contact name ________________________ Phone#__________________________________

Address______________________________ Fax#____________________________________

All requests MUST be received within one (1) year from the date of service, or it will not be considered for payment. Please return this form, along with the claim copy and supporting documentation to:

Claim Appeals:
Attention: Claims Department
P.O. Box 16423
Mesa, Arizona 85211