Provider Reconsideration Request

YouthCare HealthChoice Illinois

Please use this form to request a review of claim payment received that does not correspond with the payment expected. Matters addressed via this form will be acknowledged as requests for reconsideration only.

NOTE: Requests must be submitted within 180 calendar days from the date of service or date of discharge, whichever is later.

IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

Provider Name: _____

Provider Tax ID Number: _____

Control/Claim Number: _____

Member Name: _____

Member Number: _____

Date(s) of Service: _____

Reason for request:

- ☐ Claim was denied for no authorization; authorization # _____ obtained.
- ☐ Denied for no authorization, no referral required.
- ☐ Denied for timely filing in error (please attach proof of timely filing)
- ☐ Paid to incorrect provider
- ☐ Incorrect payment amount
- ☐ Patient credit file denials
- ☐ Other (please explain below)

_____

_____

_____

_____

Batch submission of similar/like claims

Provider Name:

Provider Phone Number:

Control Claim Numbers:

# of Claims Attached:

Explain the Issue in Detail:

NOTE: If a claim requires a correction, such as a valid procedure, location code or modifier, please follow normal process for correcting claims as this form will not be accepted for "correcting" a claim".

IMPORTANT NOTICE: Please note, a Dispute cannot be submitted until a Reconsideration is on file with YouthCare; failure to submit a Reconsideration prior to a dispute may result in denial of the dispute.

MAIL completed form(s) and attachments to:
YouthCare, P.O. Box 4020, Farmington, MO 63640-4402

Please Do Not Include a Red/White OR Carbon Copy UB nor 1500 Claim Form With Your Reconsideration Request Form