YouthCare
HealthChoice Illinois

# Provider Reconsideration Request

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 90 calendar days from the date of denial, not exceeding a year.

.

## 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 fling 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: _____

Control Claim Numbers: _____

Provider Phone Number: _____

# of Claims Attached: _____

Explain the issue in detail: _____

_____

_____

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

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

**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.

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