5.1b Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Senior Health Partners regarding a claim determination. Some of the common reasons include, but are not limited to, incorrectly processed or denied claim, the untimely submission of claims, or failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Senior Health Partners must submit a **written** request for review and reconsideration with all supporting documentation to Senior Health Partners within **90 (ninety) calendar days** from paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, must be mailed to the following location:

Senior Health Partners Claims Department
P.O. Box 958439
Lake Mary, FL 32795-8439

All written requests for Review and Reconsideration should include the following information: a copy of the EOP, the claim, any supporting documentation, and a written statement explaining why you disagree with Senior Health Partners' determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with a written request for review and reconsideration include:

- A written statement explaining why you disagree with Senior Health Partners' claim determination
- Provider's name, address, and telephone number
- Provider's identification number
- Member's name and Senior Health Partners identification number
- Date(s) of service
- Senior Health Partners claim number
- A copy of the original claim or corrected claim, if applicable
- A copy of the Senior Health Partners EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification (e.g., copy of Senior Health Partners Member ID card)
- Evidence of timely filing
    - R059/RPT-11 Report (insurance Carrier Rejection report) or Change Healthcare Vision "Claim for Review" / "Claim Summary Report
    - Please note: Senior Health Partners **does not** accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software, as proof of timely filing
- Copy of the approval number issued by the Care Management Team

Senior Health Partners will investigate all written requests for Review and Reconsideration and issue a written explanation—stating that the claim has been either reprocessed or the initial denial has been upheld—within 30 (thirty) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

Senior Health Partners will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the 90 (ninety) calendar day timeframe, the request is deemed ineligible and will be denied. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services unit at **1-877-737-2693**.