Claim Adjustment/Reconsideration Request Form

Today's Date: ______________________ **# of pages:** _______________

Please note that the timely filing for a claim adjustment/reconsideration request is 180 days from the paid/denied date.

Please do not use this form to request the following:

- **Recoupments.** A recoupment should be submitted electronically as a voided claim. For "837I" claim types, the last digit of the Type of Bill should end in "8". For the "837P" claim types, the claim frequency code should be "8". The claim number being voided must be included in the claim submission.
- **Coordination-of-benefits (COB).** All COB should be submitted electronically as replacement claims. For "837I" claim types, the last digit of the Type of Bill should end in "7". For "837P" claim types, the claim frequency code should be "7". The claim number being replaced must be included in the claim submission.

Billing Provider Information

Provider Name: _________________________________ Provider NPI/UMPI #: ________________________

Requester's Name: _______________________________________ Phone #: ____________________________

Requester's Address: ____

Claim Information

Member Name: _________________________________ Hennepin Health Member #: ____________________

Date(s) of Service: _______________________________ Claim Number(s): _____________________________

Reason for Request

❒ Payment Dispute ❒ Timely Filing ❒ Member Eligibility ❒ Clinical/Coding Edit ❒ Restricted Recipient

❒ Refund (please submit the remittance advice) ❒ Out-of-network Provider

❒ Other: ____________________________

Detailed description for request: ____

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Supporting Documentation

❒ Remittance Advice ❒ Medical Records ❒ Other: ____

Questions?

Please call Hennepin Health's Provider Services Team at **612-596-1036**, option 2.

Please fax or mail to:

Hennepin Health
Attention: Customer Services
400 S. 4th Street
Minneapolis, MN 55415

Fax: 612 -321-3786