

# Provider Claims Reconsideration & Dispute Request Form



Send this form with all pertinent medical documentation to support your request to Kelsey-Seybold Clinic. Your request will be processed once all necessary documentation is received, and you will be notified of the outcome. Please fill in all fields below as they are **required to complete your request**.

**Note: Inquiries received without the required information below may not be reviewed. Please return this completed form and any supporting documentation to:**

**By Mail:** Kelsey-Seybold Claims Administration  
Attn: Provider Disputes Unit  
P.O. Box 841649  
Pearland, TX 77584

**By Fax:** Alternatively, you may fax this completed form and supporting documentation to 713-442-9536.

## Service Provided Information:

Claim #:  
Date(s) of Service:  
Place of Service Code:  
Denial Reason Code:  
Authorization # (if applicable):

## Provider Information:

Provider Name:  
Please provide the address where you would like the resolution delivered!  
Attention:  
Address:  
State: Zip Code:  
Telephone: Fax:

## Patient Information:

Full Name: ID Number: Date of Birth:

## Reason for Request Based on EOB or Denial Notice:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> No Authorization on File              | <input type="checkbox"/> Lack of Information   | <input type="checkbox"/> Out of Network                         |
| <input type="checkbox"/> Not a Covered Benefit                 | <input type="checkbox"/> Untimely Filing       | <input type="checkbox"/> Invalid/Not Detailed Code Billed       |
| <input type="checkbox"/> Inclusive/Bundling/Unbundling         | <input type="checkbox"/> Exclusive             | <input type="checkbox"/> Underpayment Dispute                   |
| <input type="checkbox"/> Overpayment Dispute                   | <input type="checkbox"/> Exceeds Authorization | <input type="checkbox"/> Claim Not Billed as Authorized         |
| <input type="checkbox"/> Downcoding                            | <input type="checkbox"/> Duplicate             | <input type="checkbox"/> Coordination of Benefits (COB) Dispute |
| <input type="checkbox"/> Explanation of Benefits Documentation | <input type="checkbox"/> Other:                |   |

## Explanation for Request:

**Disclaimer:** If authorization for services is not obtained prior to services being rendered, review may be subject to an uphold of our original decision. Unless your contract allows otherwise, Kelsey-Seybold will pay the contracted allowable, depending on the member's plan and services provided, if we overturn our previous decision. By signing this form, you agree to these terms and will not bill the member, except for applicable cost-share/copay(s). Please fill out the form completely and keep and copy for your records.

Signature:

Date: