Provider Claims Reconsideration & Dispute Request Form

Send this form with all pertinent medical documentation to support your request to KelseyCare Advantage. 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: KelseyCare Advantage 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:

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

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, KelseyCare Advantage will pay the Medicare 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). This form is to be used when you have a payment dispute. Please fill out the form completely and keep and copy for your records.

Signature: **Date:**