



Abrazo Advantage Health Plan (HMO)

An Affiliate of Abrazo Health Care

PROVIDER RECONSIDERATION (“APPEAL”) FORM

All standard provider reconsideration (“appeals”) regarding claim payment, partial payment, or non-payment must be submitted within 60 calendar days from the date of the notice of documentation (i.e. remittance advice or notice of adverse action).

Requests for reconsideration should include:

1. A completed Provider Reconsideration Form OR a letter detailing the factual and legal basis for the dispute. **(Complete one form for each reconsideration).**
2. A copy of the original claim and remittance advice.
3. **NON-CONTRACTED** providers must submit a signed and dated Waiver of Liability Statement which states the provider will not bill the member regardless of the outcome of the reconsideration. AAHP is unable to accept the reconsideration until the waiver is received (see 42 CFR §422.600). If the waiver is not received at the conclusion of the reconsideration timeframe (60 days) the reconsideration case is forwarded to an Independent Review Entity (IRE) with a request for dismissal. The IRE is contracted with the Centers for Medicare & Medicaid and is not affiliated with AAHP.
4. Supporting documentation such as medical records, operative reports, etc. is required when the claim involves a clinical component (denied inpatient days, bundling issues, or services denied for lack of prior authorization).
5. Mail or fax the completed form(s) and documentation to:
Abrazo Advantage Health Plan Fax: 602-674-6673
Attn: Provider Appeals
7878 N. 16th St. #105
Phoenix, AZ 85020
6. Reconsiderations are acknowledged within five (5) business days. A written decision is mailed within sixty (60) calendar days from receipt of the reconsideration request. When AAHP upholds its original decision in full or in part, the case file is forwarded to the Independent Review Entity (IRE). The IRE reviews the case and makes a final determination on the reconsideration. In some cases, the provider may need to file an Independent Payment Dispute Resolution directly with the Payment Dispute Resolution Contractor. Please refer to the resolution letter upon receipt to determine which process is applicable.

Provider Information:

Date:	Provider / Group Requesting Review:		
Contact Name (First Name, Last Name):			Department:
Correspondence Address:			
Fax Number:		Phone Number:	

Member Information:

Member Name:	Date of Birth:	AAHP I.D.:
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Claim Information:

Claim / Form #:	Date of Service:						
Procedure Code(s) disputed:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; height: 20px;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>						

Reason/Supporting Information for Reconsideration

Clinical Documentation Attached Yes No

