PO Box 91110
Sioux Falls, SD 57109
(605) 328-6877 • 1-800-601-5086
Fax: (605) 328-7224
sanfordhealthplan.com

SANFORD HEALTH PLAN

Claim Reconsideration Request

Claim Information

Provider Facility:	Contact Name (Name of Person Submitting Request)	Contact Phone Number	Today's Date
Member Name	Member ID Number	SHP Claim Number(s)	Date of Service

Reason you are requesting review for this claim: (check one)

Note: Corrected or voided claims must be submitted electronically through your clearinghouse or submitted via fax or mail to the claims department; claim reconsideration forms are not to be used for these circumstances. For specific instructions on how to submit corrected or voided claims electronically, please see the Provider Manual. All requests submitted through the portal to correct or void a claim will be returned for proper submission.

☐ Timely Filing

☐ Assistant Surgeon

☐ Other: _____

_____

Required Attachment:

1. EOP on this claim
2. Required Documentation as outlined in policy: (check all that apply)

☐ Log of when claim was sent to clearing house	☐ Copy of documented attempts to obtain insurance information
☐ Proof of what insurance information was given at DOS	☐ Date of delivery
☐ Photo copy of incorrect insurance card that was presented	☐ Work Comp denial letter, MVA denial/response letter
☐ Notes documenting when the claim was sent	☐ Copy of the primary carrier's Explanation of Payment
☐ Requisition form from referring Provider's office	

Please note a response letter will be sent within 30 days of receipt of documentation.

Sanford Health Plan's policy (PR-14 Claim Reconsiderations) on claim reconsiderations is as follows:
Providers will be granted a one time review for claim reconsiderations if they feel their claim(s) was processed incorrectly. Follow up on claims processed with regards to denials, reimbursement levels, or other Sanford Health Plan determinations that effect claims processing must be submitted within 60 days from the date the Explanation of Payment (EOP) was issued to the provider. After this time frame has expired, claims will no longer be allowed to be reviewed.

"Timely" Filing if defined as:

- claims received within 180 days from the date of service or as defined in Provider Contract, date of discharge for inpatient services, or from the paid date on the primary Explanation of Payment; or
- claims received within 365 days from the date of service, date of discharge for inpatient services, or from the paid date on the primary Explanation of Payment for North Dakota Medicaid Expansion members

Please fax or mail this form along with any other documentation to Sanford Health Plan:
Attention: Provider Relations • PO Box 91110 • Sioux Falls, SD 57109-1110 • Fax: (605) 328-7224

Subrogation/Workers Compensation/Motor Vehicle Accident/Third Party: Claims must be received Timely from the date of notification or denial of claims. Required documentation includes a copy of the denial or benefit exhaustion letter.

Coordination of Benefits: In the event the Plan is the secondary payer on health insurance benefits, claims must be received Timely. Required documentation includes a copy of the primary EOP.

Initial Credentialing: Claims must be submitted Timely. Providers are not to hold claims for notification of approved Credentialing. Claim payments will be held upon completion of an approved Credentialed Status. If the Provider fails to meet credentialing requirements, claims will be processed and denied as the Provider not being eligible, which then becomes a Provider write-off.

OB/GYN Global Package Billing/Antepartum Care: Claims must be submitted Timely from the date of delivery. Required documentation includes date of delivery.

Member Responsibility: Participating Providers must file claims to the Plan Timely. If the Member fails to show his/her Plan ID card at the time of service and provider consequently bills the wrong Plan, then the Member may be responsible for payment of the claim after the Provider's timely filing period has expired. The Plan only processes claims with this denial at the Provider's request. Both the Provider and the Member will receive an EOP and Explanation of Benefits (EOB) showing this denial. The Provider at this time accepts responsibility for discussing and handling any or all issues regarding the above claim with the Member. Required documentation includes a copy of the card including any information received on the date of service, requisition form from the referring Provider's office or copy of documented attempts to obtain insurance information.

Proof of Timely Filing: Plan Participating Providers are contractually obligated to submit claims Timely. Required documentation includes screen prints from the billing system showing the date it was sent to the Plan. If claims are filed electronically, required documentation includes a dated screen print, with the documented name of the clearinghouse being used, of the claim being accepted without error by the Plan.

Newborn additions: A newborn is eligible to be covered from birth. Member's must complete and sign the Plan's enrollment application form requesting coverage for the newborn within 31 days of the infant's birth. Because of this timeframe allotted to add newborn dependents to a policy Providers should not file claims prior to the 31 days of an infant's birth. Claims received prior to the newborn being added to a policy will be denied or rejected electronically as Member not eligible.

Providers will need to re-file claims after this allotted timeframe of 31 days for proper claims processing and reimbursement.

Assistant Surgeon: Requests for reconsideration of denied Assistant Surgeon charges must be received within 60 days from the EOP. Required documentation includes a reference to the Plan claim number, code(s) being asked for reconsideration and a copy of the medical records. Milliman Care Guidelines has been for practice guidelines and medical management utilization.

Reimbursement Review: Requests for a review of reimbursement from the Plan on a code must be received within 60 days from the EOP.