THE COLORADO MEDICAL ASSISTANCE PROGRAM

P.O. Box 90
Denver, CO 80201-0030

Request for Reconsideration

All required information below must be completed. See the reverse side of the form for additional information.

Provider Identification - Required

Provider Name

Street Address

City, State, Zip Code

Billing Provider ID Number

Billing Provider NPI

Individual to Contact

Provider Telephone Number

Area Code **Number**

Client Identification - Required

Enter client's State ID Number

Date(s) of service

Date of last Provider Claim Report (PCR)

If requesting an adjustment of a paid claim, you must enter the TCN:

Important: Do not use this form to rebill claims or request routine adjustments. Use this form only after all routine processing procedures have been exhausted and the adverse action is the result of circumstances beyond the provider's control.

Identification of Attachments - Required

Please indicate the documents attached to this request. Incomplete requests will be denied or returned.

Required for all requests

- ☐ Fully completed and signed claim form(s) with all required attachments, reports and consent forms for each claim form
- ☐ Documents showing proof of compliance with ***all*** timely filing requirements for each claim form

Required, if applicable to extenuating circumstances

- ☐ Certification of delayed eligibility notification
- ☐ Eligibility documentation
- ☐ Third Party Resource payment or denial information
- ☐ Medicare payment or denial information
- ☐ PRO/PAR documentation
- ☐ Correspondence from State of Colorado
- ☐ Other documentation - Please identify

Description of Extenuating Circumstances and Reason for Reconsideration Request - Required

Provider Signature

Date

COMPLETING THE RECONSIDERATION REQUEST FORM

If claims are denied and filing requirements are not met because of circumstances beyond the control of the provider, additional review and reconsideration is available through the Colorado Medical Assistance Program fiscal agent. Providers must use and exhaust all routine rebilling and adjustment procedures before submitting a reconsideration request.

The Request for Reconsideration form must be completed and attached to the front or top of reconsideration claims. Claims submitted without the Request for Reconsideration form may be processed using routine claims processing procedures. Send the original completed reconsideration request form to the fiscal agent at: Request for Reconsideration, P.O. Box 90, Denver, CO 80201-0090. Retain a copy in your files for reference. Reconsideration request forms may be ordered from the fiscal agent.

FIELD LABEL	INSTRUCTIONS
PROVIDER IDENTIFICATION INFORMATION	All provider identification information fields must be completed.
IDENTIFICATION OF ATTACHMENTS	Each request must include a fully completed, signed, **paper** claim form with all required attachments, certifications, reports, and consent forms. If the claim was previously submitted electronically, you must prepare and sign a paper claim to include with the reconsideration request. Reconsiderations submitted without a properly completed claim form will be returned to the provider. Identify any other applicable documents submitted with the reconsideration request. This identification allows fiscal agent reviewers to identify submitted applicable documents for use during processing. **Timely Filing** Reconsideration requests must be received within the applicable timely filing period. Proof of compliance with ALL timely filing requirements must be submitted.
CLIENT IDENTIFICATION	**SINGLE CLIENT** If you are requesting reconsideration of one or more claims for a single client, attach all related claims, mark the Single Client box, and enter the State ID number for the client. **DATE(S) OF SERVICE** Identify the date(s) of service. You may enter a span of dates or indicate the word "various" if applicable. **DATE OF LAST PROVIDER CLAIM REPORT (PCR)** The date of the last Provider Claim Report (PCR) showing denial or incorrect payment must be completed and a copy of the PCR must be attached to the reconsideration request. The PCR run date is used to calculate compliance with timely filing requirements. **CHECK THIS BOX IF REQUESTING ADJUSTMENT OF A PAID CLAIM** If your request involves an adjustment of a previously PAID claim, please check this box. If the adjustment indicator box is marked incorrectly, processing may be delayed.
DESCRIPTION OF EXTENUATING CIRCUMSTANCES	Provide a concise description of the extenuating circumstances that prevented compliance with filing requirements. If supporting documentation or required claim attachments are not available, such as proof of timely filing, explain and justify why it is not possible to produce the required documents. Payment disputes should include a full explanation of the reason for requesting additional reimbursement related to exceptional circumstances including, when applicable, copies of operative reports, medical literature, manufacturer's invoices, etc. *Please note*: State regulations specify that billing and claim preparation errors resulting from employee negligence, the provider's failure to provide sufficient, well-trained employees, or the provider's failure to monitor the activities of employees and agents (billing services) are not recognized as extenuating circumstances beyond the provider's control.
PROVIDER SIGNATURE	The reconsideration request form must have an authorized signature.

REPORTING THE RESULTS OF RECONSIDERATION PROCESSING

Reconsideration processing activity is reported on the Provider Claim Report under the headings of: *Reconsiderations in Process, Reconsiderations Paid, and Reconsiderations Denied.* Reconsideration claims that are processed as adjustments to previously paid claims appear in the adjustments section of the PCR.

RECONSIDERATION DENIALS

If a reconsideration claim is denied and claim information can be corrected or if additional information or documentation is available, you may resubmit the request within 60 days of the reconsideration denial (Provider Claim Report run date). The resubmitted request must be completed in the same manner as an original reconsideration request.

If you disagree with the final decision of the fiscal agent, you may file an appeal with the Office of Administrative Courts. Appeals to the Office of Administrative Courts must be filed in writing within 30 days from the mailing date of the reconsideration denial to the Office of Administrative Courts, 633 Seventeenth Street, Suite 1300, Denver, Colorado 80202.

RECONSIDERATION PROCESSING ACTIVITY INQUIRIES

Contact Colorado Medical Assistance Program Provider Services at 1-800-237-0757.