western sky community care

PROVIDER RECONSIDERATION & APPEAL FORM

Use this Provider Reconsideration and Appeal Form to request a review of a decision made by Western Sky Community Care. The process for reconsideration and appeal is the same for participating and non-participating providers. Please see the Provider Manual for details and requirements of the reconsideration and appeal processes.

If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

All claim requests for claim disputes must be received within 90 calendar days from the date of the Medicaid Remittance. All fields below are required information. Failure to complete the form may result in a delay of your request.

All boxes immediately below are required to be completed – Do not attach another copy of the claim

Provider Name		**Provider Tax ID#**
Control/Claim Number (*Located on EOP*)		**Date(s) of Service**
Member Name		**Member ID Number**
Request Review Type (must select one):	Reconsideration (optional step)	Provider Appeal
Reason for Dispute (please check): ☐ Claim was denied for no authorization, but authorization #_____ was obtained. ☐ Claim was denied for no authorization, but no authorization is required for this service.	☐ Claim was paid to wrong provider. ☐ Claim was denied for untimely filing in error (proof of timely filing should be attached). ☐ Claim was paid for incorrect amount. ☐ Denied as duplicate in error.	☐ Retro eligibility or Retro Review no auth Requested. ☐ Coordination of benefits (please explain below). ☐ Denied Medical Necessity ☐ Other (please explain below).
Supporting comments/explanation:		
Requestor Name:		
Date of Request:		**Requestor Phone Number:**

ATTACH: A copy of the EOP with the claim number to be reviewed clearly circled. Please complete required information above and do not attach a copy of the claim. **Mail or Fax completed form(s) and attachments to:**

Western Sky Community Care
P.O. Box 5090
Farmington, MO 63640-5090
Fax# 1-833-400-0867