PAR PROVIDER
PAYMENT RECONSIDERATION FORM

Date______________________

Please complete the following form to help expedite the review of your claims reconsideration.
***Is this a**

Request for Reconsideration: you disagree with the original claim outcome (payment amount, denial reason, etc.) Please check if this is the first time you are asking for a review of the claim.

Claim Dispute: you disagree with the outcome of the Request for Reconsideration

Provider Name*	**Provider Tax ID***
Provider NPI*	**Date of last Explanation of Payment**
Arizona Claim Number*	**Date of Service***
Member Name	**Member ID**

* Indicates a required field

Reason for the reconsideration (please check all that apply):
Claim was denied for no authorization, but authorization number was obtained.
Claim was denied for no authorization, but no authorization is required for this service.
Claim was denied for Member not eligible, but member was eligible on DOS (attach eligibility information)
Claim was denied for incomplete or missing sterilization form, but one was submitted with claim (attach completed form)
Claim was not paid per the terms of my contract with Arizona Complete Health (attach relevant reimbursement section)
Claim was denied "Past Timely Filing" (attach proof of timely filing)
Claim was paid the incorrect amount (include calculation of expected payment and supporting information
Other: Please explain

____

____

Please ensure sufficient detail is provided to assist us in the review of your reconsideration or dispute.

Mail completed forms and all attachments to
Arizona Complete Health
Claims Reconsiderations & Disputes Department
PO Box 3060
Farmington, Missouri 63640-3800

Contact name & number of person requesting the appeal__________________________________