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

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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_____