BROWN & TOLAND HEALTH SERVICES

(Attach One Form Per Claim)

BROWN & TOLAND PROVIDER CLAIM RECONSIDERATION REQUEST FORM

To be used by contracted Brown & Toland providers for Medicare Advantage claims reconsideration

Note: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

- Initial inquiry should be made via telephone call to the Claims Customer Service Department at (415) 972-6002.
- This form is to be used for the reasons indicated below. This form should **not** be used if you received a letter from Brown & Toland Physicians requesting additional information required to finalize a submitted claim. In that instance, please provide the requested information along with the letter placed on top.

Date:	*** Hospital / Facility / Physician Name;**	
*** Tax ID Number:**	**NPI Number:**	*** Date(s) of Service:**
*** Patient Name:**	*** Member's Health Plan ID Number:**	**Date of Birth:**
*** Original Claim Number:** (If multiple claims, used attached spreadsheet)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**
Office Contact Name:	**Telephone Number:**	**Fax Number:**

* Indicates a required field

Reason for request: (check one)

☐ Previously denied as timely filing (attach proof of timely filing)

☐ Previously denied for 'Additional Information Not Received' (requested documentation should be attached)

☐ Claim inquiry or check tracer

☐ Resubmission of a corrected claim (explain correction below)

☐ Other – explain below:

_____

_____

_____

_____

_____

_____

INSTRUCTIONS: When submitting this form, place the form on top of all supporting documentation, which may include correspondence received from the health plan, and mail to:

BTHS – Claims CQA Dept
P.O. Box 70190
Oakland, CA 94612-0190