Seton Health Plan

A member of the Seton Family of Hospitals

CLAIM RECONSIDERATION FACE SHEET

Date: _____

To: MediView Service Accountability Unit Phone: CHIP (877) 451-5601 Fax: (512) 421-4860
Phone: Expanded EPN & EPN (512) 421-5667

From: _____ Phone: _____ Fax: _____

Member Name: _____ Member ID# _____

Claim #:_____

State Reason for Reconsideration (this form is not for Retro Authorization requests):

_____

_____

_____

_____

Attachments are required for reconsideration review.

Check Appropriate Reason:

- ❑ Processed as Inpatient vs. Observation stay
  - History & Physical
  - Copy of physician's order for observation

- ❑ Past filing deadline
  - MediView Explanation of Benefits
  - Documentation with date of original submission to another carrier (certified mail receipt, other carrier's EOB, electronic filing report, etc.)

- ❑ Reimbursement Adjustment
  - MediView Explanation of Benefits (EOB) or other payor EOB

Explanation: _____

_____

- ❑ Other:_____
  - UB92/HCFA
  - History & Physical/Office Notes
  - Discharge Summary
  - Explanation of Benefits

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MediView Internal Use Only: Incident #:_____

Provider Education: ❑ Yes ❑ No

Summary: _____