



A member of the Seton Family of Hospitals

CLAIM RECONSIDERATION FACE SHEET

Date: _____

To: MediView Service Accountability Unit Phone: CHIP & STAR (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):

Four horizontal lines for text entry.

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...

- 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: _____