Geisinger Health Plan

REQUEST FOR CLAIM RECONSIDERATION

PG:
Log#:

This form and accompanying documentation **MUST** be submitted 60 days from the date on the Explanation of Payment (EOP). **Retain a copy of reconsideration for your records. RECONSIDERATIONS SUBMITTED WITHOUT ALL OF THE NECESSARY DOCUMENTATION AND/OR AFTER THE 60-DAY LIMIT HAS EXPIRED, ARE NOT ELIGIBLE FOR RECONSIDERATION AND THE HEALTH PLAN WILL RETURN FORM TO PROVIDER'S OFFICE.**

PROVIDER NAME: _____ **DATE PREPARED:** _____

TAX ID: _____ **PERSON COMPLETING FORM:** _____

HEALTH PLAN PROVIDER #: _____ **TELEPHONE #:** _____

PLEASE SUBMIT ONE MEMBER CLAIM PER RECONSIDERATION FORM

MEMBER NAME: _____ **DOS:** _____ **CLAIM #:** _____

MEMBER ID #: _____ **PATIENT ACCOUNT #:** _____ **DOB:** _____

Provider Comments:

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REASON FOR CONSIDERATION (please check ☒:)

- ☐ **COB:** Attach a copy of the primary payer's EOP
- ☐ **DENIAL – No Precertification:** Attach medical documentation
- ☐ **DENIAL – Claim Edit:** Attach medical documentation **(only 1 claim per form)**
- ☐ **DENIAL – OTHER:** _____
- ☐ **RETRACTION OF PAYMENT:**
  Date of Service _____ Procedure Code(s) _____
- ☐ **CORRECTION:** Attach a corrected claim form
  Identify Data Change _____
- ☐ **DISPUTE –** Incorrect payment or denial: Attach supporting documentation

SUBMIT TO:

Claims Department
Geisinger Health Plan
PO Box 853910
Richardson, TX 75085-3910

Number of Pages:

_____

HEALTH PLAN USE ONLY:

_____ Approved: Reconsideration reported on EOP within 45 days of receipt.

_____ Reconsideration denied. Explanation: _____

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