Geisinger

REQUEST FOR CLAIM RECONSIDERATION

PG:
Log#:

This form and accompanying documentation MUST be submitted within 60 days from the date on the Explanation of Payment (EOP). Retain a copy for your records. Reconsiderations submitted without all the necessary documentation and/or after the 60-day limit has expired are not eligible for reconsideration and will be returned to the provider's office. PLEASE SUBMIT ONLY ONE MEMBER PER CLAIM RECONSIDERATION FORM.

Provider name: Date prepared:

Tax ID: Person completing form:

Provider NPI #: Telephone:

Member name: Claim #: DOS:

Member Health Plan ID#: Patient account #: DOB:

Reason for consideration (choose one):

- ○ **COB** — Attach copy of primary payer's EOP
- ○ **Denial, no precertification** — Attach medical documentation
- ○ **Denial, claim edit** — Attach medical documentation (one per claim form)
- ○ **Denial, other** —
- ○ **Retraction of payment** —
  Date of service: Procedure code(s):
- ○ **Correction** — Attach corrected claim form;
  Identify data change:
- ○ **Dispute, incorrect payment or denial** — Attach supporting documentation

Type of plan (choose one):

- ○ **HMO**
- ○ **PPO**
- ○ **Geisinger Gold**
- ○ **GHP Family (Medicaid)**
- ○ **GHP Kids (CHIP)**
- ○ **TPA**

Provider comments:

Mail form to:

Claims Department
Geisinger Health Plan
P.O. Box 160
Glen Burnie, MD 21060

HEALTH PLAN USE ONLY

☐ Approved: reconsideration reported on EOP within 45 days of receipt.

☐ Reconsideration denied. Explanation: