PROVIDER RECONSIDERATION REQUEST

Today's Date: _____

Use this form as part of NH Healthy Families Claim Reconsideration Request process.

NOTE: A *Request for Reconsideration* must be submitted prior to submitting a "Claim Dispute". Reconsideration requests MUST be received within 180 calendar days of the determination letter, EOP, or Reject.

All fields in the box immediately below are required information.

Provider Name	Provider Tax ID#
NH Healthy Families Control (Claim) Number	Date(s) of Service
Member Name	Member (ID) Number

Reason for Reconsideration Request:

_____

_____

_____

Reference Materials or Knowledge Base Article:

_____

Supporting Contract Language / DHHS Regulation / Billing Guide:

_____

NOTE: If claim(s) also required a correction, such as a valid procedure code, location code, or modifier, please submit the corrected claim following the "Corrected Claim" process in the Provider Billing Guide. **Please do not include this form with a corrected claim.**

Mail completed forms and attachments to:

NH Healthy Families Attn:
Reconsideration
P. O. Box 4060
Farmington, MO 63640-3831

Important Notice: NH Healthy Families will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be (1) reprocessing your claim and issuing a notice to you on a current EOP and payment, or (2) A determination that reprocessing is not appropriate and issuing you a letter to that effect.