# PROVIDER RECONSIDERATION REQUEST

Today's Date: _____

Use this form as part of New Hampshire 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:

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

**Important Notice:** New Hampshire 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.