HEALTH TRADITION

P.O. Box 21191 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

Claim Resubmission Request Form

This form is required for resubmission(s) only when submitting a claim for the following reasons: Corrected Claims, Timely Filing Denial, Provider Appeal, Resubmitted with primary EOP, Other.

Do not use this form for: New claims or charges that were already denied as noncovered services. Original claims should be submitted electronically or by mail.

Date Requested_____

Claim#_____

Date of Service_____

Patient Name_____

Member ID#_____

Total Billed Amount_____

Billing Tax ID#_____

Billing NPI#_____

Billing Provider Name_____

Contact Name_____

Contact Phone_____

Contact Email/Fax_____

☐ **Corrected Claims:** When submitting a corrected claim, please include a corrected CMS-1500/UB-04 and Medical Records. Medical Records are required. Corrected claims include, but are not limited to, the items below:

- Late Charges
- Specify Removed Charges
- Corrected Dollar Amounts
- Corrected Provider or Service Location
- Corrected Diagnosis Code(s)
- Corrected Date of Service
- Corrected Procedure Code(s)
- Corrected Modifier(s)

☐ **Timely Filing Denial:** When submitting a request to review a timely filing denial, please include the following:
Proof of Original Submission:

- **For Electronic Claims:** Copy of your clearinghouse transactions verifying the electronic claim was submitted within timely filing limits under your Provider Agreement along with verification Health Tradition accepted or rejected the claim. Include proof that the transaction is for the patient and for the date of service in question.
- **For Paper Claims**: Screen print of accounting software verifying date of original submission of the paper claim and proof it is for the patient and date of service in question.

☐ **Provider Appeal:** Medical records/clinical documentation and provider contact information is required. Of note, submission of lab results only will result in continued denial of claim.

☐ **Resubmitted with primary EOP:** Please include the original explanation of payment from the primary insurance for the original claim.

☐ **Other:** Please include as much detailed information as possible to help in reviewing the request. This would include the following situations:

- Denied as duplicate in error.
- Disputed payment and/or contract discount.
- Other, please explain, be specific:_____

_____

Send this form by mail/fax with the required documents to: Health Tradition Health Plan
ATTN: Claims Resubmission Request
P.O. Box 21191
Eagan, MN 55121
FAX: 608.781.9654