

Claim Review Request

INSTRUCTIONS

1. You must submit this form within one hundred and twenty (120) days of PRA receipt.
IMPORTANT: Submitting a Claim Review Request is not the same as filing a Claim Appeal. You have 120 days from the date of the PRA to file a Claim Appeal. If you file only a Claim Review Request, the 120 days will continue to elapse until you either file a Claim Appeal, or the 120 days time frame expires.
2. Do not use this form to file an Appeal or to request claim status.
To file an Appeal, use the **Provider Appeal Request** form.
To check claim status, contact the Claims Department toll-free at **1-800-348-5548**
3. Submit to: **Preferred Care Network**
Claims Review
P.O. Box 30448
Salt Lake City, Utah 84130-0448
4. Attach copy of PRA or EOB, CMS-1500 or UB04 claim form (if submitting a corrected claim), or any additional information as requested. No new claims should be submitted with the form.

You may NOT submit a Claim Review Request by fax. A response will be issued within thirty (30) days of receipt of the Claim Review Request. Review of claim does not guarantee payment.

Provider Information: Physician Hospital Other health care professional (Lab, Durable Medical Equipment (DME), etc.)

Provider Name		Date Form Completed	
Facility/Group Name		Tax ID Number (TIN)	
Contact Name	Phone Number	Email Address	

Patient Information

Member Name	Member ID	Date of Birth
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Claim Information

Claim#	Date of Service	Denial Reason	Billed Amount
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Reason for review:

- 1. Previously denied or closed as "Exceeds Filing Time"
- 2. Previously denied or closed for "Additional Information"
- 3. Previously denied or closed for "Coordination of Benefits" Information
- 4. Resubmission of a corrected claim
- 5. Claim not reimbursed at contractual rate. Expected compensation: _____
- 6. Resubmission of "Prior Notification Information"
- 7. Resubmission of a claim with "Bundled" services
- 8. Other (*explain below*)

Signature	Date
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