ambetter. FROM arizona complete health.

PROVIDER REQUEST FOR POST SERVICE CLAIM PAYMENT ISSUE RESOLUTION

Please complete this form to assist Ambetter from Arizona Complete Health (AzCH) ensure that we process your claims payment issue under the appropriate resolution process. All fields are required information:

Provider Name:	**Provider Tax ID #:**
Control/Claim Number:	**Date(s) of Service:**
Member Name:	**Member (RID) Number:**

SELECTED RESOLUTION PROCESS

☐ **Claim Resubmission.** Request for reprocessing of a claim with corrections. Filing Timeframe: 365 days from the initial claim Explanation of Payment (EOP). Required Documentation: corrected claim, and other supporting documentation.

☐ **Claim Reconsideration.** Requesting reprocessing of a claim with corrections, or additional information not previously submitted. Filing timeframe: 365 calendar days from the EOP. Required Documentation: Detailed information on reason for reconsideration, medical records, and other applicable supporting documentation.

☐ **Provider Grievance Level 1.** Attempts to resolve claims payment issue through resubmission or reconsideration processes unsuccessful. Request to formally review claim payment issue. Filing Timeframe: 365 calendar days from the date of the EOP. Required Documentation: Copy of EOP, detailed statement of dispute. Any additional supporting documentation that demonstrates claim processed incorrectly for AzCH to consider.

☐ **Provider Grievance Level 2**. If not satisfied with the AzCH Grievance Level 1 decision, requesting a second level review of the claims payment issue. Filing Timeframe: 60 calendar days from the date of the AzCH Level 1 Closure Letter. Required Documentation: Include an explanation for disagreements with the Level 1 closure letter, and additional information for AzCH to consider in its review of the issue.

☐ **Health Care Appeal (Level 2).** Request to file an appeal for a claim payment denial on behalf of member**.** Filing timeframe: 2 years from the date of the Explanation of Benefit (EOB) or Explanation of Payment (EOP). Required Documentation: Cover letter detailing reason for appeal, a copy of the EOP, and applicable records and documents for AzCH to consider.

Refer to the Provider Manual Addendum available on the website for more information.
**Please note: Any photocopied, black & white, or handwritten claim forms, regardless of the submission type causes an upfront rejection.*

RESOLUTION PROCESS SUBMISSION REASON

☐ Claim rejected for missing or incorrect information.
☐ Claim for covered service incorrectly denied as not covered.
☐ Claim denied for no authorization, but authorization obtained (authorization #_____).
☐ Claim denied for no authorization, but authorization NOT required for this service
☐ Claim denied for untimely filing in error (attach proof of timely filing)
☐ Claim denied for global/unbundled procedure (attach medical records)
☐ Claim paid to the wrong provider
☐ Claim paid for the incorrect amount
☐ Other (please explain) _____

Requestor Name:_____
Requestor Phone Number:_____
Date of Request:_____