

Postservice Appeal and Claim Dispute Form For Contracted Providers



Complete the top section of this form. Check the box that most closely describes your appeal or dispute reason. Include any supporting documentation, as indicated below. We can't process requests received without required information.

If your request is related to a preservice denial, use the correct form on the [HealthSpring.com/Providers](https://www.healthspring.com/Providers) forms page.

Request for appeal or claim disputes and reconsiderations			
Member first name		Middle initial	Member last name
Member identification number			
Date of birth / /	Claim number		Line item number
Dates of service			
Provider or contact name	National Provider Identifier		Phone
			Fax

Contracted provider appeals	
Reason for appeal	
<input type="checkbox"/> Observation or inpatient medical <input type="checkbox"/> Medical necessity denial <input type="checkbox"/> No prior authorization <input type="checkbox"/> Service provided before authorization was effective <input type="checkbox"/> Service not covered by Medicare	<input type="checkbox"/> Duplicate claim If the original claim was denied for any of the above reasons for appeal, please check this box and the original denial reason listed. <input type="checkbox"/> Postservice claim audit or payment recovery for any of the listed reasons.

Submit appeals to: HealthSpring Part C Appeals
PO Box 650065
Dallas, TX 75265

Fax: 855-699-8985

Claim disputes or reconsideration	
Reason for dispute or reconsideration:	
<input type="checkbox"/> Coordination of benefits <input type="checkbox"/> Invalid or missing modifier <input type="checkbox"/> NPI or tax identification number mismatch <input type="checkbox"/> Invalid diagnosis or Current Procedure Terminology (CPT®) codes <input type="checkbox"/> Claim was not paid in accordance with contract allowable rate <input type="checkbox"/> Not within the scope of contract <input type="checkbox"/> Medically unnecessary edits <input type="checkbox"/> Request for additional information <input type="checkbox"/> Include copy of letter or request received <ul style="list-style-type: none"> • Provide missing or incomplete information <ul style="list-style-type: none"> - Coding dispute - Timely filing • Remittance advice, explanation of benefits or other documentation of filing original claim 	<input type="checkbox"/> Date of service on claim does not match authorization <input type="checkbox"/> Member not effective on date of services <input type="checkbox"/> Service or item not covered <input type="checkbox"/> Exceeds benefit limit <input type="checkbox"/> Quantity billed exceeds amount authorized <input type="checkbox"/> Not a covered benefit <input type="checkbox"/> Member in hospice <input type="checkbox"/> Lack of medical records <input type="checkbox"/> Bundled service <input type="checkbox"/> Claim timely filing denials <input type="checkbox"/> Additional information required <input type="checkbox"/> Itemized bill required <input type="checkbox"/> Duplicate claim If the original claim was denied for any of the listed reasons for dispute/reconsideration, please check this box and the original denial reason listed. <input type="checkbox"/> Postservice claim audit or payment recovery for any of the listed reasons

Submit disputes to: HealthSpring Services
Attn: Medicare Claims Department
Contracted Provider Payment Disputes
PO Box 1004
Nashville, TN 37202

If you have multiple reconsideration requests for the same health care professional and payment issue, indicate this in the notes below and include a list of the following: member ID number, claim number and date of service.

If the issue requires supporting documentation as noted above, it must be included for each individual claim. If no additional documentation is required for your appeal or reconsideration request, fax in only this completed cover sheet.

You may use the space below to clearly describe your reason for appeal or claim dispute or reconsideration.