INTRODUCING:
UNIVERSAL PROVIDER REQUEST FOR CLAIM REVIEW FORM

The Massachusetts Health Care Administrative Simplification Collaborative*, a multi-stakeholder group committed to reducing health care administrative costs, is proud to introduce the ***updated*** Universal Provider Request for Claim Review Form and accompanying reference guide. *This standard form may be utilized to submit a claim to a health plan or MassHealth for additional review. An accompanying reference guide provides valuable information in one location*.

The following organizations now accept the form:

- Blue Cross Blue Shield of Massachusetts
- Boston Medical Center HealthNet Plan
- Fallon Health
- Harvard Pilgrim Health Care
- Health New England
- MassHealth
- Neighborhood Health Plan
- Tufts Health Plan

**Participants of the collaborative include: HealthCare Administrative Solutions, Inc., the Employers Action Coalition on Healthcare, Massachusetts Association of Health Plans, Massachusetts Health Data Consortium, Massachusetts Hospital Association, Massachusetts Medical Society, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, Neighborhood Health Plan, Fallon Health, Health New England, Boston Medical Center HealthNet Plan, MassHealth (adhoc), UniCare, Wellpoint, UnitedHealthcare, Partners HealthCare, Winchester Hospital, North Adams Regional Health Center, Jordan Hospital, Harrington Hospital, Baystate Medical Center, and Atrius Health.*

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REFERENCE GUIDE — REQUEST FOR CLAIM REVIEW

Organizations that Utilize the Request for Claim Review

This guide will help you to correctly submit the Request for Claim Review Form. The information provided is not meant to contradict or replace a payer's procedures or payment policies. If there are any inconsistencies between these guidelines and the respective payer's provider manual, regulations, or other plan requirements, the payer's provider manual, regulations, or other plan requirements govern and shall take precedence over information contained in this reference guide. For-up-to-date details, please consult the respective payer's Provider Manual, regulations, or other plan requirements. Please direct any questions regarding this guide to the plan to which you submit your request for claim review.

Please note that failure to abide by the following may affect your compliance with a payer's individual policies.

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TERMINOLOGY/DEFINITIONS USED IN THIS DOCUMENT

Contract Terms	Belief that processed claim was not paid in accordance with contract terms/rates resulting in either an under- or overpayment.
Coordination of Benefits	• Resubmission of a claim previously denied for other primary insurance with supporting documentation from other payer. • A reply to a request for other insurance information.
Corrected Claim	Original claim denied as the claim requires an attribute correction (e.g., incorrect member, incorrect member ID number, incorrect date of service, incorrect/missing procedure/diagnosis code/location code, incorrect count, and modifier added/removed).
Duplicate Claim	• A first time claim submission that denied for, or is expected to deny for duplicate filing. • Original claim or service lines within a claim that denied as a duplicate.
Filing Limit	• A first time claim submission that denied for, or is expected to deny for untimely filing. • When the member did not identify himself or herself as a payer's member (misidentified member). • A re-review of a claim denied for insufficient filing limit documentation.
Payer Policy — Clinical	Provider believes that the final claim payment was incorrect because of an associated clinical policy.
Payer Policy — Payment	Provider believes that the final claim payment was incorrect because of global reimbursement or (un)bundling of billed services (e.g., claim editing software).
Pre-certification/Notification or Prior-Authorization Denials	• A claim denied because no notification or authorization is on file. • A claim denied for exceeding authorized limits.
Referral Denial	• A claim submission denied for a missing/invalid PCP referral that is greater than 90 days from the date of service and within 180 days from the original denial (Note: Claims denied for a missing/invalid PCP referral that are within 90 days from the date of service may be corrected and resubmitted as a first time claim submission via paper or EDI). • A claim for a POS member paid at the out of network rate due to invalid/missing PCP referral information on the claim form. • A re-review of a claim denied for a missing/invalid PCP referral that is within 180 days from the original denial date.
Request for Additional Information	• A first time claim submission that denied for additional information. • An unlisted procedure code not submitted with supporting documentation. • A procedure code that was denied or not submitted with operative notes, anesthesia notes, pathology report, and/or office notes.
Retraction of Payment	Provider requests a retraction of entire payment or service line (e.g., member on claim was not your patient or service on claim was not performed). Note: Multiple retractions can be submitted with one review form — write "multiple" in the Member ID field.
Other	A review request not covered by any aforementioned category; please provide specific background and documentation in support of a request.
MassHealth Final Deadline Appeal*	A MassHealth final deadline appeal must satisfy all the requirements of MassHealth regulations at 130 CMR 450.323, including meeting the criteria at 130 CMR 450.323(A) and including the required documentation specified in 130 CMR 450.323(B) to substantiate the contention that the claim was denied or underpaid due to MassHealth error.

*Please see page #15 for specific MassHealth Final Deadline Appeal information.

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Category	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Filing Limit	Initial Filing Limit (days). *Defined as the number of days elapsed between the date of service (or EOB date, if another insurer is involved) and the receipt by a plan.*	• HMO-90 Medicare Advantage-90 • PPO-365 • Indemnity-365	• Commercial-90 • MassHealth 150	90	90	120	90	180	90	90	• Commercial-90 • Tufts Medicare Prefered-60
Request for Review Form	Form required?	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
Address to Submit Review Requests		BCBSMA/Provider Appeals P.O. Box 986065 Boston, MA 02298	BMC HealthNet Plan Attn: Provider Appeals P.O. Box 55282 Boston, MA 02205	Corrected Claims Box 3080 Claim Dispute Box 3000 Farmington, MO 63640	Commonwealth Care Alliance P.O. Box 22280 Portsmouth, NH 03802-2280	Fallon Health Attn: Request for Claim Review / Provider Appeals P.O. Box 211308 Eagan, MN 55121-29081	For all products unless noted below: Harvard Pilgrim Health Care P.O. Box 699183 Quincy, MA 02269-9183 • **Passport Connect** Mail to the address on the back of the member's ID card • **Health Plans Inc.** Refer to the Health Plans, Inc. product page in the *HPHC Provider* Manual. • **Harvard Pilgrim** Student Resources Refer to the **Student Resources** product page in the HPHC Provider Manual.	Health New England One Monarch Place Suite 1500 Springfield, MA 01144	Neighborhood Health Plan Attn: Claims and Correspondence 399 Revolution Drive, Suite 940 Somerville, MA 02145	Tufts Health Plan Attn: Provider Disputes P.O. Box 9194 Watertown, MA 02471-9194	• **Tufts Health Plan** Provider Payment Disputes P.O. Box 9190 Watertown, MA 02471-9190 • **US Family Health Plan** Provider Payment Disputes P.O. Box 9195 Watertown, MA 02471-9900 • **Tufts Medicare Preferred HMO** Provider Payment Disputes P.O. Box 9162 Watertown, MA 02471-9162 • **Tufts Health Plan SeniorCare Options** Provider Payment Disputes P.O. Box 9162 Watertown, MA 02471-9162
Fax # to Submit Review Requests		N/A	N/A	N	N/A	N/A	N/A	N/A	(617) 526-1902	N/A	N/A

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Category	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Can multiple similar requests be submitted with one form?		Y	N	N	Y	Y	N* *Multiple requests accepted for *Retraction of Payment Requests* only.	N	N	N	N
Initial Review Timeframes	**Initial Denied Claim Review Timeframes.** Defined as the # of days from original appeal determination on the appeal resolution letter.	365	• Commercial-90 • MassHealth 150	90	90	120	90 day initial appeal filing limit from date of claim adjudication/EOP	365	90	60	90 for filling limit appeals, 180 from the original adjudication for corrected claims and duplicate claim denials
Subsequent Requests to Review Same Claim	Second Level Review?	Yes — if new information is provided.	Yes — with supporting documentation not previously submitted.	Y	N	N	Filing Limit: Yes — 2 nd level review/ appeal — filing limit 90 days from the date of the first level appeal determination. • Duplicate Claim, Referral Denial, Corrected Claim: Yes — within 180 days from date of original denial • Pre-certification/Notification or Prior-Authorization, Contract Rate, Payment or Clinical Policy: Yes within 30 days of date on original review resolution letter • Consult specific policy for further details.	Yes — with supporting documentation not previously submitted.	Y	Yes — with supporting documentation not previously submitted.	N/A
	Time allowed to file?	365	30	90	N/A	N/A	30	N/A	60	60	N/A
	How Defined?	As the # of days from adjusted remittance date.	30 days from date of appeal denial letter.	90 days from receipt of level 1/ reconsideration denial.	N/A	N/A	As the # of days from the original appeal determination on an appeal resolution letter.	N/A	60 days from receipt of Level I appeal denial letter.	From date of disputed remittance.	N/A
	Third Level Review?	Yes — if new information is provided.	N	N	N	N	N	N	N	N	N/A
	Time allowed to file?	365	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	How defined?	As the # of days from adjusted remittance date.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Category	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Vehicles for Submission	Ways to submit a Request for Claim Review:										
	Mail	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Phone	Y*	N	Y	N	N	Y*	N	N	Y	N
	eTool	Y*	N	N	N	N	N	Y	Y	N	Y
	Other	N	N		N	Fax	N	N	Fax	Y*	N
	Comments:	*Not all review requests can be submitted over the phone or via eTool.					*Limited instances related to notification.			*Fax — in some instances.	

Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Contract Term(s)	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/ Corrected)	N	N	N	N	N	N	N	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	N	N	N	N	N	N	N	N
	Other supporting documentation (clinical or other)	Y	Y	Y	Y	Y	Y	Y	Y	N	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Comments:									Claim # and supporting documentation.	

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Coordination of Benefits	Request for Claim Review Form	Y	N	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/Corrected)	N	N	N	N	N	Y	Y	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	Y*	Y	N	N	N*	Y*	N	Y*	N
	Other supporting documentation	N	N	N	N	N	N	Y	N	N	N
	Other Payer Remittance Advice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Comments:	Copy of *Primary Insurer's* remittance advice required.	*EOP of the appealed BMCHP claim not required — but will require OI EOP		Copy of *Primary Insurer's* remittance advice required.	Copy of *Primary Insurer's* remittance advice required.	Copy of *Primary Insurer's* remittance advice required. *Refer to the COB Policy within the *HPHC Provider Manual.*	*EOP of the appealed HNE claim not required — but will require OI EOP	Copy of *Primary Insurer's* remittance advice required.	*OI EOP required	Copy of *Primary Insurer's* remittance advice required.
Corrected Claim	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/Corrected)	N*	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	Y	N	N	N	N	N	N	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Other supporting documentation (clinical or other)	N	N		N	N	N	Y	N	N	N
	Other Payer Remittance Advice	N	N	N	N	N	N	N	N	N	N
	Comments:	*If no payment made on original claim and still within initial filing limits, new claim should be filed versus submitting an appeal.									

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Duplicate Claim	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/ Corrected)	N	N	N	N	Y	Y	N	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	N	N	N	N	N	Y	N	N
	Other supporting documentation (clinical or other)	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Other Payer Remittance Advice	N	N		N	N	N	N	N	N	N
	Comments:	If multiple services rendered on the same DOS — documentation should show differentiation between the services (e.g., different times/ different locations, etc.).	If multiple services are rendered on the same DOS — documentation should show differentiation between the services (e.g., different times/ different locations, etc.).	If multiple services rendered on the same DOS — documentation should show differentiation between the services (e.g., different times/ different locations, etc.).	If multiple services rendered on the same DOS — documentation should show differentiation between the services (e.g., different times/ different locations, etc.).	For multiple services rendered on the same DOS — supporting documentation should show differentiation between the services (e.g., different times/ different locations, etc.).		If multiple services rendered on the same DOS — documentation should show differentiation between the services (e.g., different times/ different locations, etc.).		Claim # and supporting documentation.	

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Filing Limit	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/ Corrected)	N	Y	N	N	N*	Y	Y	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	Y	N	Y	N	Y	Y	N	Y
	Other supporting documentation (clinical or other)	Y*	Y	Y	Y	Y	Y*	Y	Y	Y	Y
	Other Payer Remittance Advice	N*	Y		N	N	N	Y	N	N	N
	Comments:	*Provider should refer to the *BlueBook* for complete listing of acceptable documentation.	The following are considered acceptable proof of timely submission: • EOB from primary insurance. • Proof that the member or another insurance carrier was billed. EDI transmission report if claims were submitted electronically.	Computer printout of patient account ledger. • EOB from primary insurance. • Proof that the member or another insurance carrier was billed.	The following are considered acceptable proof of timely submission: • Computer printout of patient account ledger. • EOB from primary insurance. • Proof that the member or another insurance carrier was billed.	*Provider should refer to the *FH Provider Manual* for supporting documentation requirements.	*Provider should refer to the *Filing Limit Appeal Policy* within the *Harvard Pilgrim Provider* Manual for supporting documentation requirements.		*Provider should refer to the *NHP Provider Manual* for complete listing of acceptable documentation.	Claim # and supporting documentation.	Provider should refer to the *Filing Limit Adjustments* section in the Claims Requirements Chapter of the *Tufts Health Plan Provider Manual* for supporting documentation requirements.

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Payer Policy — Clinical	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/ Corrected)	N	N	N	N	N	N	N	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	Y	N	N	N	N	N	N	N
	Other supporting documentation (clinical or other)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Other Payer Remittance Advice	N	N	N	N	N	N	N	N	N	N
	Comments	Payer Policy Clinical = Individual Consideration (e.g., Medical Technology denials).		Claim # and supporting documentation.	Payer Policy Clinical = Individual Consideration (e.g., Medical Technology denials).					Claim # and supporting documentation.	
Payer Policy — Payment	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/ Corrected)	N	N	N	N	N	N	N	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	Y	N	N	N	N	N	N	N
	Other supporting documentation (clinical or other)	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Other Payer Remittance Advice	N	N	Y	N	N	N	N	N	N	N
	Comments:	Example: Inclusive service denials.		Claim # and supporting documentation.	Example: Inclusive service denials.					Claim # and supporting documentation.	

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Pre-cert/ Notification/ Authorization Denial or Reduced Payment	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/Corrected)	N	Y	N	N	N	N	Y	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	Y	Y	N	N	N	Y	Y	N	N
	Other supporting documentation (clinical or other)	N*	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Other Payer Remittance Advice	N	N	N	N	N	N	Y	N	N	N
	Comments:	This appeal process is to request an adjustment for claims, which have denied for Pre-cert/ Authorization and a valid Pre-cert/Authorization is now on file. Appeals to overturn a denied Pre-cert/Authorization or request Pre-cert/ Authorization follows the Clinical Appeals process as outlined in the *BlueBook* and would not fall under this review process for claims.		This appeal process is to request an adjustment for claims, which have denied for prior authorization. (To appeal a denial for Medical Necessity, please follow the clinical appeals process as outlined in the *CeltiCare Provider Manual*.)	Use this appeal process to request adjustment of claims denied for no Pre-cert/ Authorization where a valid Pre- cert/ Authorization is now on file. This process is also to be used for denied clinical appeals related to Pre-cert/ Authorization and Level of Care appeals.	Use this appeal process to request adjustment of claims denied for no Pre-cert/ Authorization where a valid Pre-cert/ Authorization is now on file. This process is also to be used for denied clinical appeals related to Pre-cert/ Authorization and Level of Care appeals.			Claim # and supporting documentation.	Claim # and supporting documentation.	

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Referral Denial	Request for Claim Review Form	Y	N/A — Referrals not required	Y	Y	Y	Y	N/A (We don't require referrals.)	Y	Y	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/Corrected)	N	N/A	N	N	Submit corrected claim.	Y	N/A	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N/A	Y	N	N	N	N/A	Y	N	N
	Other supporting documentation (clinical or other)	Y	N/A	Y	Y	N	N	N/A	Y	Y	Y
	Other Payer Remittance Advice	N	N/A	N	N	N	N	N	N	N	N
	Comments:			Claim # and supporting documentation.		Corrected claim should be submitted with Referring Physician's name and NPI #.				Claim # and supporting documentation.	
Request for Additional Information	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	N	• Yes — for paper claim adjustments. • No — for online claim adjustments.
	Claim Form (Original/Corrected)	N	N	N	N	N	N	Y	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	N	N	N	N	Y	N	N	N
	Other supporting documentation (clinical or other)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Other Payer Remittance Advice	N	N	N	N	N	N	Y	N	N	N
	Comments:			Claim # and supporting documentation.			Include Case # when indicated on appeal letter.			Claim # and supporting documentation.	

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Type of Review	Documentation Requirement	BCBSMA	BMCHP	Celticare	CCA	FH	Harvard Pilgrim	Health New England	NHP	Tufts Health Public Plans	Tufts Health Plan
Retraction of Payment	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	Yes — for paper claim adjustments.
	Claim Form (Original/ Corrected)	N	N	N	N	N	N	N	N	N	N
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N*	Y	Y	N	N	N	Y	N*	N	Y
	Other supporting documentation (clinical or other)	N*	Y	Y	N*	N*	N	Y	N*	N	N
	Other Payer Remittance Advice	N*	Y	N	N	N	N	Y	N	N	N
	Comments:	*Request must indicate reason for retraction. If for Other Insurance (OI), OI EOP must be included.	Request must indicate reason for retraction.	Request must indicate reason for retraction. If for Other Insurance (OI), OI EOP must be included.	*Please specify reason for retraction.	*Please specify reason for retraction.	Please specify reason for retraction.	Please specify reason for retraction.	*Request must indicate reason for retraction. If for Other Insurance (OI), OI EOP must be included.	Request must indicate reason for retraction.	Please specify reason for retraction.
Other	Request for Claim Review Form	Y	Y	Y	Y	Y	Y	Y	Y	N	N/A
	Claim Form (Original/ Corrected)	N	Y	N	N	N	Y	Y	N	N	N/A
	Remittance Advice (EOP) or equivalent electronic data (i.e., portal screenshot, NEHEN output, etc.)	N	N	Y	N	N	N	Y	N	N*	N/A
	Other supporting documentation (clinical or other)	Y	Y	Y	Y	Y	Y	Y	Y	N*	Y
	Other Payer Remittance Advice	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
	Comments:	Dependent upon the reason for the appeal/review.	Dependent upon the reason for the appeal/review.	Dependent upon reason for appeal.	Dependent upon the reason for the appeal/review.	Dependent upon the reason for the appeal/review.	Dependent upon the reason for the appeal/review.	Dependent upon the reason for the appeal/review.	Dependent upon the reason for the appeal/review.	*EOP is preferred. Additional documentation dependent upon the reason for the appeal/review.	Dependent upon the reason for the appeal/review.

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MASSHEALTH			
MassHealth Final Deadline Appeal	Request for Claim Review Form	Yes	MassHealth Final Deadline Exceeded Appeals of Erroneously Denied or Underpaid Claims are governed by MassHealth Regulations at 130 CMR 450.323. All such, Appeals must be submitted to the Final Deadline Appeal Unit within 30 days after the date on the remittance advice that first denied the claim for exceeding the final billing deadline. Electronic submitters can submit appeals to MassHealth via the Provider On Line Service Center at: https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop MassHealth strongly encourages all providers with electronic capability to submit Final Deadline appeals electronically. **Only providers with an approved electronic claim waiver can submit paper claims and appeals to:** Final Deadline Appeal Unit 100 Hancock Street 6th floor Quincy, MA 02171 Please refer to the following links for additional information regarding MassHealth's electronic appeal submission process and Final Deadline Appeal Q&A: www.mass.gov/eohhs/docs/masshealth/bull-2011/all-221.pdf MassHealth will provide a link to the appeal FAQ here. Providers must continue to meet the criteria outlined in the MassHealth All Provider Regulations and Appeal Procedures. For more information, please read the 130 CMR 450.323: Appeals of Erroneously Denied or Underpaid Claims.
	Claim Form (Original/Corrected)	Yes	
	Plan Remittance Advise (EOP)	Yes	
	Other supporting documentation (clinical or other)	An appeal must meet the conditions outlined at MassHealth All Provider Regulations 130 CMR 450.323 (A) and must include all supporting documentation as specified in 130 CMR 450.323(B) to substantiate the contention that the claim was denied or underpaid because of MassHealth's error.	
	Other Payer Remittance Advice	Required for TPL submissions only	
	Can multiple similar requests be submitted with one form?	No	
	Vehicles for submission	DDE via the Provider online Service Center (POSC)	
	Comments:		

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REQUEST FOR CLAIM REVIEW FORM

COMPLETE ALL INFORMATION REQUIRED ON THE "REQUEST FOR CLAIM REVIEW FORM."
INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

Today's Date (MM/DD/YY):	Health Plan Name:
**Denotes required field(s)*	
PROVIDER INFORMATION	
*Provider Name:	*Contact Name:
*National Provider Identifier (NPI):	*Contact Phone Number:
Contact Fax Number:	Contact Email Address:
*Contact Address:	
MEMBER/CLAIM INFORMATION	
*Member ID:	*Member Name:
*Date(s)of Service (MM/DD/YY):	
*Claim Number:	*Denial Code:
***REVIEW TYPE**	
Enter X in one box, and/or provide comment below, to reflect purpose of review submission.	

	Contract Term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms.
	Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.
	Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made:
	Duplicate Claim: The original reason for denial was due to a duplicate claim submission.
	Filing Limit: The claim whose original reason for denial was untimely filing.
	Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
	Payer Policy, Payment: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
	Pre-certification/Notification or Prior-Authorization or Reduced Payment: The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
	Referral Denial: The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
	Request for Additional Information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC codes, home infusion therapy).
	Retraction of Payment: The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).
	MassHealth: The MassHealth provider has received a *Final Deadline Exceeded* error message. MassHealth providers must only use this review type to submit claims for review to MassHealth. Use of this form for submission of claims to MassHealth is restricted to claims with service dates exceeding one year and that comply with regulation 130CMR 450.323.
	Other:

Comments (Please print clearly below):

Attach all supporting documentation to the completed "Request for Claim Review Form."