Health Partners Plans

Request for Claim Reconsideration

Please complete this form and include all supporting documents (up to 25 claims). Incomplete submissions **will not** be accepted. For submissions with more than 25 claims, please submit another form with all supporting documents.

If you have questions, contact Health Partners Plans at **1-888-991-9023**.

Please send a completed form and all documents to:

Health Partners Plans
Attn: Claims Reconsideration
Claims Reconsideration
901 Market Street, Suite 500
Philadephia, PA 19107

Date:	**HEALTH PLAN:** Health Partners Plans

PROVIDER INFORMATION

Name (Last, First):	Contact Name:
Tax ID:	Phone:
NPI:	Email:

MEMBER INFORMATION
Note: If submitting more than one claim with the same member information, complete only one time.

Member Name (Last, First):	Member ID:
Claim Number:	Date(s) of Service:
Number of Claims:	Remark Code:

REVIEW TYPE: Please note the reason for your appeal.

- ☐ Claim/service denied as unauthorized
- ☐ Claim/service denied or, paid as non-par
- ☐ Claim not paying according to contract
- ☐ Claim/service denied as duplicate in error
- ☐ Fee schedule updated
- ☐ Inpatient admission denied, outpatient corrected claim attached
- ☐ Service code/modifier corrected
- ☐ Other: _____
- ☐ TPL updated
- ☐ Additional lines added
- ☐ DRG review, no medical records needed
- ☐ NDC code added
- ☐ Implants/devices invoice attached
- ☐ Primary EOP attached
- ☐ Itemized bill for denied days attached