SENDERO HEALTH PLANS

CLAIM RECONSIDERATION REQUEST FORM

This form is to be used when a provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. No new claims should be submitted with this form. Please submit a separate form for each claim.

☐ **Level I Reconsideration:** Mail: Sendero Health Plans Attn: Reconsideration PO Box 17307 Austin, TX 78760	☐ **Level II Appeals:** Email: SenderoClaims@senderohealth.com Or Mail: Sendero Health Plans Attn: Appeal II PO Box 17307 Austin, TX 78760

Date form completed: _____

Member information

Member ID:	Claim#:	Date of Service:
Member Name: Last	First	

Physician/health care professional information

Contact Person:	Phone Number:	Email address:
Mailing address for response:		
Physician Name (as listed on Provider Remittance Advice or Explanation of Payment):		Amount Owed
Facility/Group Name		Tax Identification Number (TIN):

Reason for reconsideration request

1. Timely Filing – Acceptable proof of timely filing includes certified receipt showing delivery of claim to the correct claims address AND/OR copy of the electronic acceptance report with the patient information and claims information from the clearinghouse.
2. Pricing
3. Eligibility
4. Code Review
5. Other (explain below)

Description of Claim Reconsideration request

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a Level II Appeal Request to SenderoClaims@senderohealth.com OR Mail to: Sendero Health Plans, P.O. Box 17307, Austin TX 78760