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:**<br>Sendero Health Plans<br>ATTN: Claims<br>PO Box 759<br>Austin, TX 78767 | ☐ **Level II Appeals:**<br>Email SenderoClaims@senderohealth.com<br>OR Mail to<br>Sendero Health Plans<br>ATTN: Claims<br>2028 East Ben White Blvd., Ste 400<br>Austin, TX 78741 |

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-ATTN Claim Appeals, 2028 E Ben White Blvd, Ste 400, Austin TX 78741

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