Request for Claim Review Form

WellSense HEALTH PLAN

Date: _____

Please complete all information required on this form. Incomplete submissions will be returned unprocessed.

Provider Information		
*Provider name	*Contact name	
*NPI #	*Contact phone	
Contact fax	Contact email	
*Contact address		
*City	*State	*Zip

Member/Claim Information	
*Member ID	*Member name
*Date(s) of service (mm/dd/yyyy)	
*Claim number	*Denial code

***Review Type**

Enter X in one box, and/or provide comment below, to reflect purpose of review submission.

Origination Date: November 2013
Last Updated: April 2023

	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.)
	Other:

Comments:

Mail form to:

WellSense Health Plan
Attn: Claims Department
P.O. Box 55049
Boston, MA 02205

Updated April 2023