THE OHIO STATE UNIVERSITY
HEALTH PLAN

REQUEST FOR CLAIM RECONSIDERATION

This form and accompanying documentation can be submitted up to one full year (365 days) from the date on the Explanation of Payment (EOP). Please allow for a 30-day turnaround and retain a copy of reconsideration for your records. **RECONSIDERATIONS SUBMITTED WITHOUT ALL OF THE NECESSARY DOCUMENTATION AND/OR AFTER ONE YEAR, ARE NOT ELIGIBLE FOR RECONSIDERATION AND THE HEALTH PLAN WILL RETURN FORM TO PROVIDER'S OFFICE.**

PROVIDER NAME: _____ **DATE:** _____

TAX ID: _____ **PERSON COMPLETING FORM:** _____

EMAIL: _____ **TELEPHONE #:** _____

If submitting multiple claims, please check here: ☐

If submitting a single claim, please complete the member information and claim fields below:

MEMBER NAME: _____ **DOS:** _____ **CLAIM #:** _____

MEMBER ID #: _____ **PATIENT ACCOUNT #:** _____

BILLED AMOUNT: _____ ☐ **OPPOC MEMBER** ☐ **OSUHP MEMBER**

Provider Comments:

REASON FOR RECONSIDERATION (please check ☒):

☐ **COB:** Attach a copy of the primary payer's EOP

☐ **PROCESSED OUT OF NETWORK**

☐ **UNDERPAYMENT/OVERPAYMENT**

☐ **DENIAL — TIMELY FILING**

☐ **DENIAL — Claim Edit:** Attach medical documentation **(only 1 claim per form)**

☐ **DENIAL — OTHER:** _____

☐ **RETRACTION OF PAYMENT:**
Date of Service _____ Procedure Code(s) _____

☐ **CORRECTION:** Attach a corrected claim form
Identify Data Change _____

☐ **DISPUTE —** Incorrect payment or denial: Attach supporting documentation

SUBMIT TO: **Provider Relations**
Email: OSUHealthplanPR@osumc.edu
Fax: (614)-292-1166

INTERNAL USE ONLY: **IHB #:** _____

_____ Approved: Reconsideration reported on EOP within 45 days of receipt

_____ Reconsideration denied. Explanation: _____