DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:

- ☐ Sterilization consent form
- ☐ Primary insurance EOP
- ☐ Invoice
- ☐ Itemized bill (inpatient hospital claims or as requested)
- ☐ Unlisted procedure code documentation
- ☐ Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Note: No form is required for the submission of corrected claims. Please refer to the *Corrected Claim Process* section of the Magnolia Health Provider Manual.

OR

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was denied due to lack of Mississippi Provider Medicaid enrollment. The TPI is: _____
- ☐ Claim was not paid per the terms of my contract with Magnolia Health. Please explain and advise of your payment expectation/amount:

_____

_____

- ☐ Other. Please explain.

_____

_____

_____

☐ **Check box if this Reconsideration Request is for multiple claims.** Please attach a separate list if more than one claim number and/or member ID is related to this reconsideration request.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
Magnolia Claim Number*	Dates of Service*
Member Name*	Member ID*

Required fields

A Claim Reconsideration may be submitted in 3 ways: mail, fax, or via secure web portal.

Mail to:	**Fax to:**	**Secure web portal:**
ATTN: Claim Reconsideration PO BOX 3090 Farmington, Missouri 63640-3800	**833-950-3857**	**https://www.magnoliahealthplan.com/login.html**

Please ensure sufficient detail is provided to assist us in the review of your Reconsideration.

Contact name & number of requestor: _____

Request Date:_____