Authorization Reconsideration Request Form (Authorization Appeal or Clinical Claim Dispute)

(Form required when submitting an Authorization Appeal or a Clinical Claim Dispute request)

Number of faxed pages (including cover sheet): _____

Authorization Appeal or Clinical Claim Dispute (Authorization Reconsideration)

- A second review of a denied authorization within 30 days of the date of the denial/non-approval authorization (Pre claim) or,
- A second review of a denied authorization post-claim within 365 days of the date of service, or within 60 days of the remittance advice; whichever is later (Medicaid line of business)
- Changes in coding (Pre/Post Claim)
- Add on procedures (Pre/Post Claim)
- Extenuating Circumstances Post Claim (as defined in the Provider Manual). Please note in your comments if there are extenuating circumstances.

Authorization Appeal (Pre-Claim Reconsideration)

Please fax this completed form and any supporting documentation to:

- Medicare/MyCare Ohio Inpatient: (844) 834-2152
- Medicare Outpatient: (844) 251-1450
- MyCare Opt-In Outpatient*: (844) 251-1451
  *Excludes Home Health
- MyCare Opt-In*: (877) 708-2116
  *Home Health & Hospice Room & Board T2046 Only
- Transplant*: (866) 449-6843
  *All lines of business
- Medicaid/MyCare Ohio Opt-Out (866) 449-6843
- Marketplace: (833) 322-1061
- Imaging and Special Tests*: (877) 731-7218
  *All lines of business
- Radiation Therapy
  - Medicaid & Marketplace: (877) 731-7218
  - Medicare: (844) 251-1450
  - MyCare Ohio Opt-In: (844) 251-1451

Authorization ID: _____

Clinical Claim Dispute (Post-Claim Reconsideration)

Please upload this completed form and any supporting documentation through the following methods:

- Availity Essentials Portal Appeal Process
- Verbally (Medicaid line of business): (855) 322-4079
- Post-Claim Fax: (800) 499-3406
- Medicare Non-Par Fax: (562) 499-0610

Authorization ID: _____ Claim ID: _____

Member Information	
Member Name:	Date of Denial/Non-approval:
Member ID:	Service Request:
Date of Birth (DOB):	

Provider Information	
Provider Name:	Phone Number:
Facility Name:	Fax Number:
Contact Name:	Disc Password (if applicable):

Please send clinical notes and any supporting documentation. Please refer to your denial rationale for specific information required.

- Related diagnostic testing
- Treatments tried, and the effect and outcome
- Assessment and/or evaluation notes
- For Home Health, service notes and OASIS Form/485

This form is not intended to be used for Non-Clinical Claim Disputes such as administrative denials and coding edits.