Request for Claim Review Form

wellsense.org |877-957-1300 option 3

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.	
	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 (PLEASE PRINT CLEARLY)	

Mail form to:

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

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