



Provider Portal

Request for Claim Review

WellSense Health Plan requires the use of the Request for Claim Review Form for all EDI claim corrections and claim re-adjudication requests. Filing a corrected claim helps reduce the potential for a claim to deny as a duplicate.

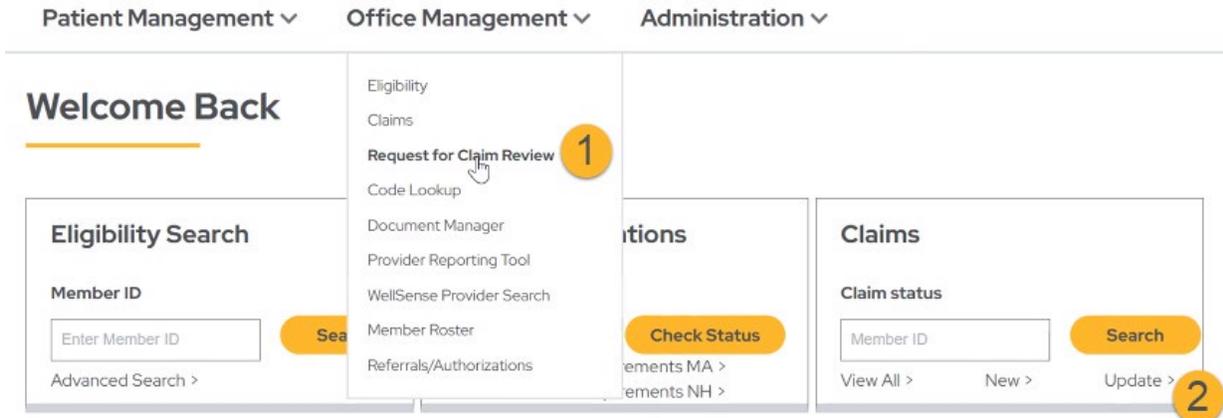
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Points of Entry for Requesting a Claim Review

Once you have logged into the provider portal, there are two entry points for requesting a claim review:

1. Hover over the **Office Management** menu item and click **Request for Claim Review** – OR –
2. Click **Update**, in the Claims search section, to access the **Request for Claim Review**.



Completing a Request for Claim Review Form

There are a total of five sections to complete:

1. **Provider Information**
2. **Member Information**
3. **Claims Information**
4. **Review Type**
5. **Provide Documentation**

Required fields are marked with *

The screenshot shows the "Request for Claim Review" form. The form is titled "Request for Claim Review" and has a sub-header "Complete all information required. Required fields are marked with *". The form is divided into five sections: "Provider Information", "Member Information", "Claim Information", "Review Type", and "Provide Documentation". The "Provider Information" section includes fields for "Provider ID" (a dropdown menu), "Contact Name", "Phone Number", "Fax Number", "E-mail Address", "Address 1", "Address 2", "City", "State" (a dropdown menu), and "Zip". The "Member Information" section includes fields for "Member ID", "Member Name", and "Product" (a dropdown menu). The "Claim Information" section includes fields for "Date of Service" (with a calendar icon), "Claim Number", and "Denial Code".

Provider Information

Complete the ten fields:

1. **Provider ID ***: NPI or Name
2. **Contact Name ***
3. **Phone Number ***
4. **Fax Number**
5. **E-mail Address**
6. **Address 1 ***
7. **Address 2**
8. **City ***
9. **State ***
10. **Zip ***

Request for Claim Review

Complete all information required. Required fields are marked with *

Provider Information

Provider ID *

Contact Name *

Phone Number *

Fax Number

E-mail Address

Address 1 *

Address 2

City *

State *

Zip *

Member Information

Complete the two required Member Information fields:

1. **Member ID***
2. **Member Name***

Member Information

Member ID *

Member Name *

Product *

Claim Information

Complete the three required claims fields:

1. **Date of Service ***
2. **Claim Number ***
3. **Denial Code ***

Claim Information

Date of Service *

Claim Number *

Denial Code *

Review Type

1. **Contract terms:** Selected when the provider is questioning the applied contracted rate on a processed claim.
2. **Coordination of Benefits (COB):** Selected when submitting a primary EOB.
3. **Corrected Claim:** Selected when a change is being made to a previously processed claim. Both will have the same claim ID. Identify the changes being made by selecting the appropriate option in the drop down.
4. **Duplicate Claim:** Selected when submitting proof of non-duplicate services.
5. **Filing Limit:** Selected when submitting proof of on time claim submission.
6. **Payer Policy, Clinical:** Selected when the provider is questioning the applied clinical policy on a processed claim.
7. **Pre-Cert/Pre Auth:** Selected when submitting proof of authorized services.
8. **Referral Denial:** Selected when claims are denied for invalid or missing PCP referral.
9. **Request for Additional Information:** Selected when submitting medical records, invoices, or other supportive documentation.

Review Type

You must select at least 1 review type. *

- Contract Terms**
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. Other health insurance is primary; EOB must be attached
- Third Party Liability**
Motor Vehicle 2k or 8K PIP Exhaust letter/ Workers Comp/ GL Carrier denial letter. Attorney Representation letter (MVA, GL or WC)
- Corrected Claim**
The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.).
- 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.
- 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.).

10. **Retraction of Payment:**

Selected when retracting an entire payment or removing service line data.

Provide Documentation

EDI with document submission:

Attach an image of the required data to support the claim review or correction.

Up to 10 files or 45 MB total file size.



Submission Request for Claims Review Confirmation

Scroll to the bottom of the page and click **Submit Request for Claim Review** to submit your claim.

A confirmation screen will appear saying **Claim Submitted**.