WellSense HEALTH PLAN

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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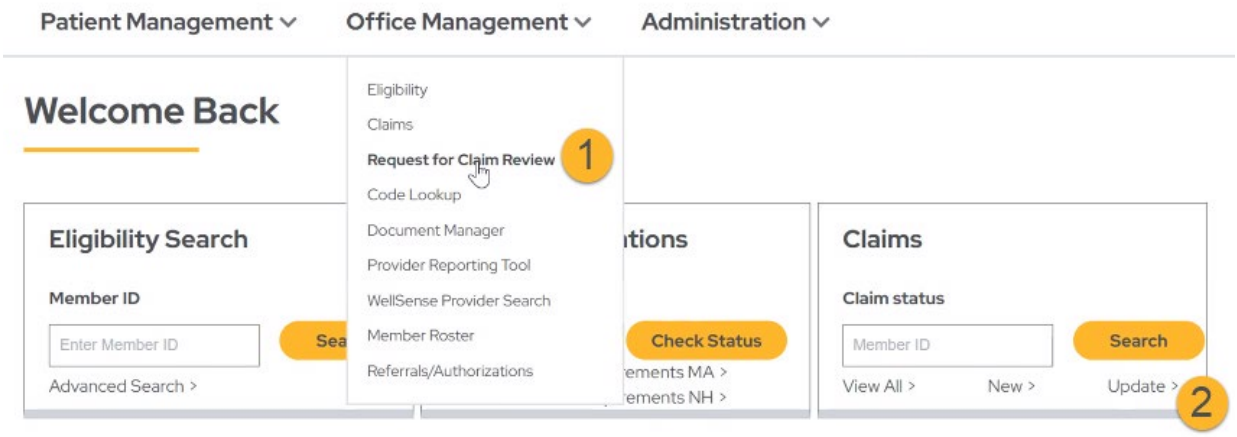
Points of Entry for Requesting a Claim Review

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.**

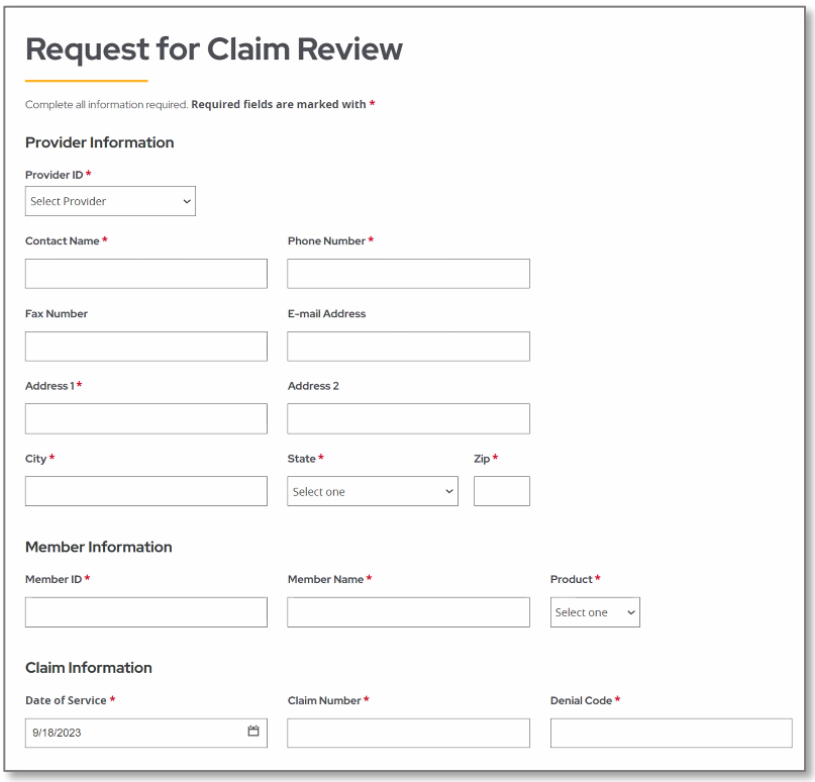


Completing a Request for Claim Review Form

There are a total of five sections to complete:

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

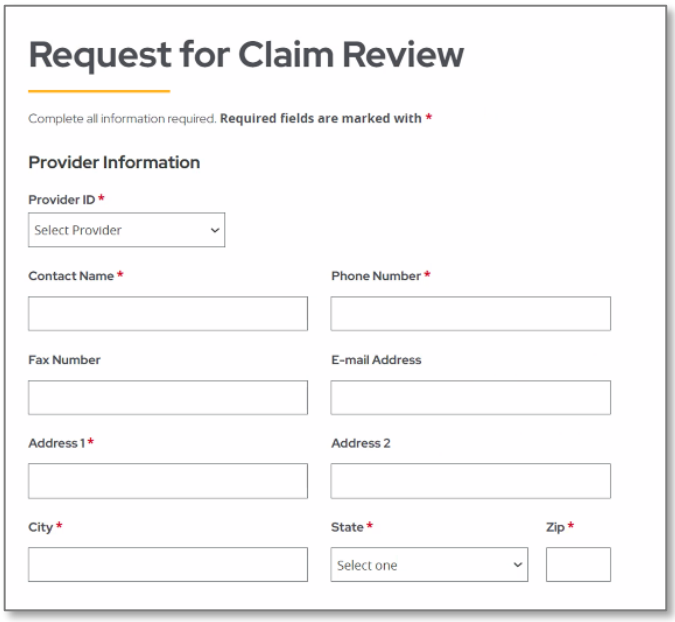
Required fields are marked with *



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** *



Member Information

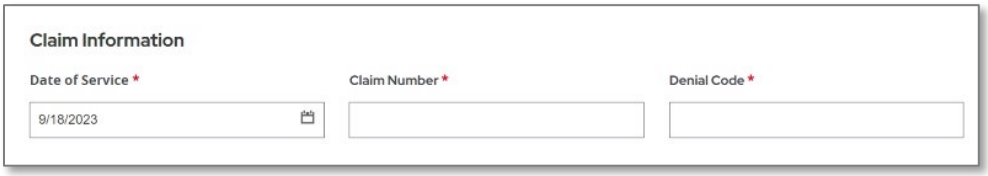
Complete the two required Member Information fields:

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

Claim Information

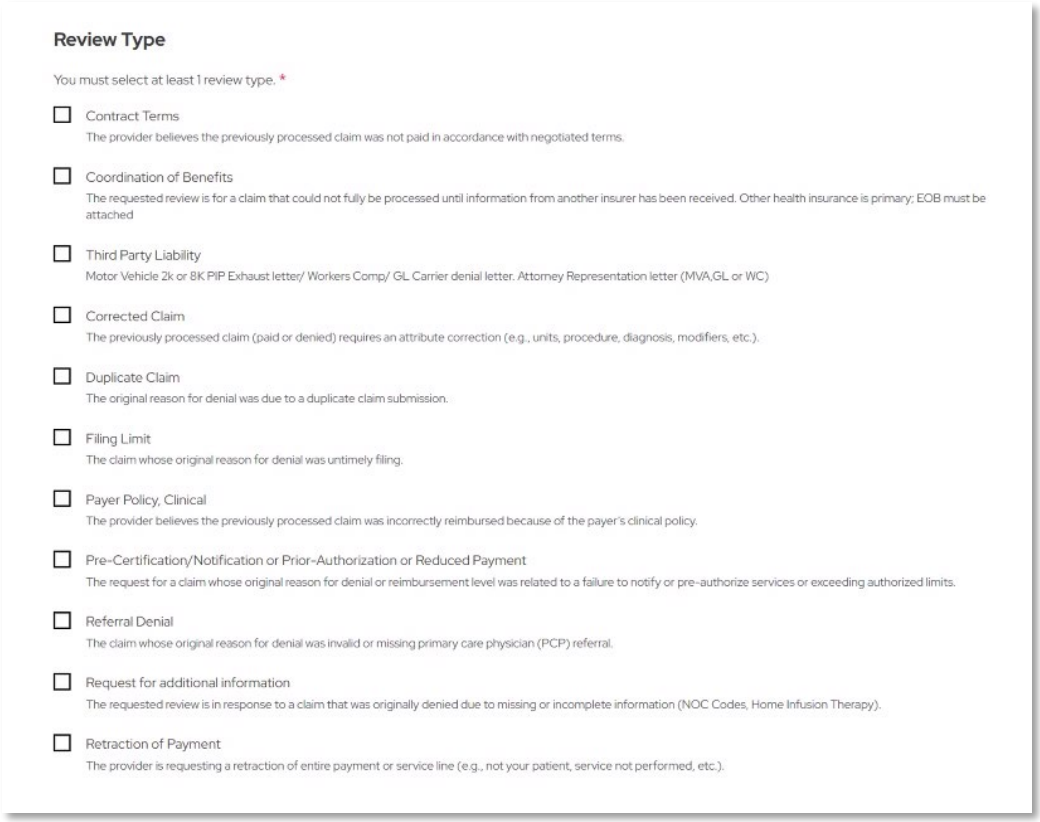
Complete the three required claims fields:

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

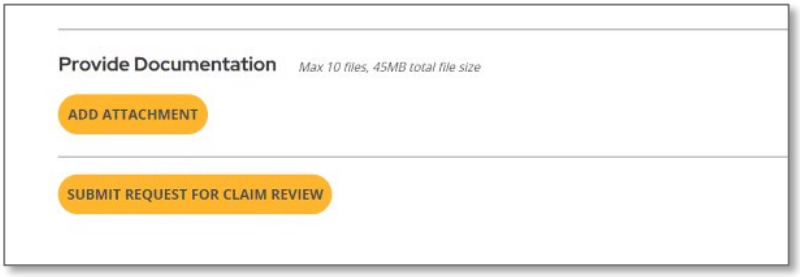


10. **Retraction of Payment**: Selected when retracting an entire payment or removing service line data.

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**.