QualChoice® HEALTH INSURANCE

Request for Reconsideration

*Do not use as an Appeal Form.**

This form to be completed by QualChoice contracted physicians, hospitals or other healthcare professionals requesting claim reconsideration for members enrolled in QualChoice health plans. Please submit a separate form for each claim. Form must be completed and submitted with required documentation. Incomplete forms may be returned. Please attach any additional information applicable to the request. Corrected claims should be submitted electronically. If the claim in question has had no payments to date or you are submitting additional information for initial review of payment, please forward to the address on the back of the patient's ID card.

Mail: QualChoice, P.O. Box 25610, Little Rock, AR 72221
Email: CLReconsider@QualChoice.com

Form must be on top of all required documents being submitted.

Please check one: ☐Physician ☐Hospital ☐Other Healthcare Provider

Section I. Member Information

Member ID	Claim # (as listed on the EOB or RA)	Date of Service (as listed on the RA or EOB)	Billed Amount

Member Name: Last	First	MI

Street Address	City	State	Zip

Patient Name: Last (if SAME as Member, mark SAME)	First	MI

Section II. Practitioner/Hospital/Other Healthcare Provider

Tax Identification Number (TIN)	Phone No.	Email Address

Physician Name (as listed on RA or EOB): Last	First	MI

Street Address	City	State	Zip

Facility/Group Name	Contact Person

Section III. Person Completing this Form

Name	Phone No.	Email Address

Section IV. Reason for Reconsideration Request. You must check (✓) one of the following.

CLAIMS

☐ Previously denied/closed for additional information
☐ Duplicate charges (e.g., multiple charges with same CPT) — Provide medical record documentation.
☐ Corrected Claim
☐ Payment received for wrong provider or member—Provide details in Comments section.
☐ Duplicate payment received. **Check One: ☐ Recover Funds ☐ Refund Enclosed**
☐ Claim Check/Claim edit denial (i.e., mutually exclusive, incidental, global dispute period, etc.) — Provide medical record documentation.
☐ Modifier Reimbursement — Provide medical record documentation.
☐ Medical Record Request — When sending requested medical records, attach the QualChoice request letter or provide claim #.

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☐ Claims Timely Filing — Provide Acceptance Report from EDI Vendor and demonstration of timely follow-up.
☐ Provider Fee Schedule/Contract Language — Provide detailed explanation of your reconsideration request in the comments section.

Comments: Include detailed information as to the nature of your request.

Possible attachments for supporting documentation: • Copy of RA or EOB • Other required attachments as listed above

*Clinical denials (such as not medically necessary, experimental and investigational or when claim amounts are provider liability) are not eligible for the reconsideration process and should be handled via ***Provider Appeal Form***, found at ***QualChoice.com***. ***Select Providers, Forms/Information***.