

Claim Appeal/Resubmission Form

This form should be used to resubmit a denied or rejected claim for reconsideration.

Date: _____

Section I—Claim Detail

Member name: _____

Member ID #: _____

Date of service: _____

Section II—Reason for Resubmission/Appeal

- | | |
|--|--|
| <input type="checkbox"/> Medical record attached | <input type="checkbox"/> Legible claim attached |
| <input type="checkbox"/> Itemized statement attached | <input type="checkbox"/> NPI# correction/added |
| <input type="checkbox"/> TPI# correction/added | <input type="checkbox"/> Proof of timely filing attached |
| <input type="checkbox"/> Member eligibility correction | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical necessity appeal | |

Section III—General Information

Appeal Filing—A claim appeal must be filed within 120 days from the date of denial for reconsideration. When filing an appeal, please attach documentation supporting your claim.

A medical necessity appeal must be filed within 30 days of receipt of the denial notice.

Electronic Appeals—Electronic claims can be resubmitted electronically if the claim is resubmitted within 95 days from the date of service without incurring a past timely filing denial. Claims outside of the 95 days should be resubmitted via mail with the appropriate proof of timely filing attached.

*Appeals and resubmissions can be sent by electronic submission or via US mail to:
Texas Children's Health Plan
PO Box 300286
Houston, TX 77230-0286*

Fax submissions will not be accepted.