oklahoma complete health

CLAIM DISPUTE COVER LETTER

Use this form as part of the Oklahoma Complete Health request for formal reconsideration or appeal for re-evaluation or exception to a plan policy or contract requirement such as medical necessity, benefit limitations, eligibility, failure to obtain authorization or timely filing. This form must be filled out in full and sent in with the request.

Name/ Address of person submitting appeal: Click or tap here to enter text.	Date: Click or tap here to enter text.
Provider Name: Click or tap here to enter text.	Provider Tax ID Number: Click or tap here to enter text.
Control/claim Number: Click or tap here to enter text.	Date(s) of service: Click or tap here to enter text.
Member Name: Click or tap here to enter text.	Member ID Number: Click or tap here to enter text.

Reason for Request:

☐ Claim was denied for untimely filing error (attach proof of timely filing)

☐ Claim was denied for global/ unbundled procedure (attach medical records)

☐ Claim was paid incorrectly based on expected reimbursement or contracted rates

☐ Claim was denied for no authorization, but authorization # _____ was obtained

☐ Claim was denied for no authorization, but no authorization is required for this service

☐ The authorization on file was denied for medical necessity (attach appeal letter and medical records)

☐ Claim was denied for benefit limitations

☐ Other (please explain):

_____

_____

_____

Mail or fax completed form and attachments to:

Oklahoma Complete Health
Appeals Department
P.O. Box 8060
Farmington, MO 63640-8060

Fax: (833) 951-1150