CONDUENT
P. O. Box 23078
Jackson, MS 39225

CLAIM RECONSIDERATION FORM

Instructions: Please ensure the reconsideration request is fully completed and returned with all required documentation/attachments, reports, consent form(s), and paper claim form, with signature if applicable. If the claim was previously submitted electronically, a paper claim is still required. Reconsiderations submitted without proper documentation and a completed claim form will delay review of the request.

Beneficiary Name: _____ MS Medicaid ID#:_____
TCN: _____ Paid Date: _____ Date of Service: _____
Provider#:_____ Provider Name: _____
Provider Contact: _____ Telephone#: _____
Provider Address: _____
Procedure Code(s): _____ Diagnosis Code(s): _____

Claim Exception Code Edit(s): Please indicate the edit(s) noted on your Remittance Advice:

0104 0238 0280 0297 0432 0434 0435 0438 0439 0612
0673 0675 3222 6560 6562 Other:

_____

Please include detailed information regarding the reason your claim has been resubmitted for reconsideration. If your claim has been corrected and attached, please specify corrections that have been made.

_____
_____
_____
_____

Please indicate all applicable documents you have submitted with the reconsideration request:

___Consent Form	**___Corrected Claim**	**___Description of Unlisted Code**
___H&P Assessment	**___Lab Report(s)**	**___Medication Administration Record (MAR)**
___Operative/Procedure Notes	**___Pathology Report(s)**	**___Proof of Timely Filing**
___Ultrasound Report(s)	**___Other: (Please Specify)_____**	

Please Check:

___Have you completed the Claim Reconsideration Form?
___Have you attached a completed and signed original paper copy claim?
___Have you attached any additional substantiating information for review?

Mail to: CONDUENT, Attn: Medical Review, P. O. Box 23080, Jackson, MS 39225

Revised: January 2017