



Completing the
Electronic Claim
Reconsideration
Request Form





CLAIMS

COMPLETING THE ELECTRONIC CLAIM
RECONSIDERATION REQUEST FORM

© Neighborhood Health Plan of Rhode Island
910 Douglas Pike
Smithfield, R.I. 02917
1-800-459-6019 (Main)



1. To request a reconsideration review of a previously denied claim, BOTH of the following items are required for each individual claim. Please have them ready for upload before starting the form.
 - a) Applicable Remittance Advice for the claim
 - b) Medical notes
2. All fields marked with an * are required and must be completed to successfully submit the form.
3. Enter the Member ID and Date of Birth to validate member eligibility. If an incorrect Member ID and/or Date of Birth is entered, left blank, or if the Member ID is not in effect on the Date of Service Start, an error message “No members found with the provided criteria” will appear. Incorrect or missing data in these fields must be revised in order to continue with the form submission.

Member Information

Enter Member ID and Date of Birth to validate Member before proceeding with the form.

Member ID *

11 of 11 max characters

Member DOB *

MM/DD/YYYY

Date of Service Start *

MM/DD/YYYY

Date of Service End *

MM/DD/YYYY

Member Name *

First
Last

No members found with the provided search criteria

- When a valid Member ID, Date of Birth and Date of Service are entered, the Member's first and last names will be auto-populated.

Member Information

Enter Member ID and Date of Birth to validate Member before proceeding with the form.

Member ID *

10 of 11 max characters

Member DOB *

Date of Service Start *

Date of Service End *

Member Name *

<input type="text" value="Jane"/>	<input type="text" value="Doe"/>
<small>First</small>	<small>Last</small>

- Similarly, entering a valid Group Billing NPI number will auto-populate the Group Billing Name.

Provider Information

Group Billing NPI *

10 digits

Group Billing Name *

- Provide complete and accurate contact information to prevent missed or delayed communications.
- Upload the applicable Remittance Advice and medical notes in the section indicated. Only PDF or Word documents (files with a pdf, doc, or, docx extension) are supported. The maximum file size that can be uploaded per form is 24MB.

File Upload. Reconsideration requests with claims attached will be returned to the sender. *

Drop files here or

Accepted file types: pdf, doc, docx, Max. file size: 24 MB.

8. After filling out the form, click “Review.” If there are any errors, they will be identified at the top of the page as well as next to each affected field. Correct the errors and click “Review” again.

There was a problem with your submission. These errors are specified in text and highlighted below.

Contact Name - This field is required.
Contact Email - This field is required.
Phone Number - This field is required.
Description - This field is required.

File Upload. Reconsideration requests with claims attached will be returned to the sender. - This field is required.
CAPTCHA - The reCAPTCHA was invalid. Go back and try it again.

9. On the Review page, ensure that everything is accurate, then click “Submit.”
10. Once the form is submitted, a confirmation message and a reference number appear at the top of the screen.

Claim Reconsideration Request Form

Your request has been submitted and confirmed received. Your reference number is 111111111111.

Click here to submit another [Claim Reconsideration Request Form](#)

11. A confirmation email is also sent to the email address provided on the request form.

Your request has been submitted and confirmed received. Your reference number is 111111111111. Please do not reply to this email.

For status regarding this request please call Provider Services at **800-963-1001** with your reference number. Please allow 30 days for a determination before calling.