

Request for Claim Review Form

COMPLETE ALL INFORMATION REQUIRED ON THE "REQUEST FOR CLAIM REVIEW FORM".
INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to Customer Service at 855-696-4333 and select "Claims" option

Today's Date (MM/DD/YY):				Medical Indemnity Fund			
<i>*Denotes required field(s)</i>							
Provider Information							
*Provider Name:				*Contact Name:			
*National Provider Identifier (NPI):				*Contact Phone Number:			
Contact Fax Number:				Contact E-mail Address:			
*Contact Address:							
							
Member / Claim Information							
*Member ID:				*Member Name:			
*Date(s) of Service (MM/DD/YY):							
*Claim Number:				*Denial Code:			
*Review Type							
Enter X in one box, and/or provide comment below, to reflect purpose of review submission.							
Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.							
Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.) Please specify the correction to be made:							
Duplicate Claim: The original reason for denial was due to a duplicate claim submission.							
Filing Limit: The claim whose original reason for denial was untimely filing. Please provide evidence of due diligence in trying to meet timely filing.							
Pre-Certification/Notification or Prior-Authorization or Reduced Payment: The request is for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.							
Request for additional information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (e.g., DRG Codes, manufacturers invoice, description of respite care provided, etc.)							
Retraction of Payment: The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.)							
Other:							
Please specify							
Comments (Please print clearly below):							