Adjustment & Appeal Communication Process

Below you will find the steps necessary to submit a claim for reprocessing (adjustments or appeals).

PROCESS FLOW:

All Scott & White Health Plan claims submitted for reprocessing (adjustments & appeals), **except RightCare Medicaid Claims**, must be mailed to:

Scott & White Health Plan
ATTN: Claims Review Dept.
P.O. Box 21800
Eagan, MN 55121-0800

1. Provider or inquiring party must provide the information on the "Provider Claims Appeal Request Form". **See attachment 1**
2. Should there be multiple claims in question an Excel spreadsheet, providing the same information as the "Provider Claims Appeal Request Form" is acceptable. Attach the Excel spreadsheet to a copy of the "Provider Claims Appeal Request Form".
3. If the Claims Appeal Form or Excel spreadsheet are not completed as requested above, it will be returned to the requestor for completion.
4. The "Provider Claims Appeal Request Form" received by mail will be processed within 30 days of receipt.

APPEAL LEVEL REQUIREMENTS

Level I – Initial Appeal
Provider has 90 days after the adverse determination date of the claim to file an appeal (Out-of-State facilities have 1 year). SWHP has 30 days from date of receipt to process the appeal.
Please provide:

- Completed "Provider Claim Appeal Request Form"
- Any pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records)

Level II & III – Second & Final Level Appeal
Provider has 45 days from the date on the Initial appeal resolution to file a secondary appeal unless the original appeal was past the 90 day timely appeal deadline. SWHP has 30 days from the date of receipt to process the appeal.
Please provide:

- Completed "Provider Claim Appeal Request Form"
- Scott & White Health Plan's first/second level provider appeal response letter
- Additional pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records)

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

☐ Level I – First level appeal submission

☐ Level II & III – A first and second level appeal had been submitted and appealing resolution

Provider Claim Appeal Request Form

(This form should not be used for RightCare Medicaid claim appeals.)

In order to expedite the process of your request, this form is required. **Please complete all of the following information for each appeal. If not completed, the correspondence will be returned to the provider for correction.** Corrected claims are no longer accepted with this form. Please submit as a new claim to the below address.

Review Submission Date: _____ Contact Name: _____

Provider Name: _____ Contact Phone Number: _____

Provider# **or** NPI: _____ Member Name: _____

Provider Address: _____ SWHP Member ID#: _____

SWHP Claim number: _____ Date Of Service: _____

Choose the reason for appeal that best represents your request:

☐ **Filing Limit**

☐ **Contracted Rate or Payment Policy**

☐ **Data Entry Error**

☐ **Overpayment/Underpayment** (specify): _____

☐ **Other** (specify): _____

☐ **Claim Check/Code Editing**

☐ **COB**

Please attach any pertinent supporting documentation (i.e., surgical notes, office visit notes, pathology reports, and/or medical records) and mail it to the below address.

Scott & White Health Plan
Attn: Provider Appeals
P O Box 21800
Eagan, MN 55121-0800

****Faxed claim requests are not accepted. ****

Providers have 90 days after the adverse determination date of the claim to file an appeal. Out-of-state facilities have 1 year.