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

SCOTT & WHITE HEALTH PLAN RIGHTCARE-MEDICAID
ADJUSTMENT & REDETERMINATION REQUEST COMMUNICATION PROCESS

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

PROCESS FLOW:

All Scott & White Health Plan (SWHP) RightCare claims submitted for redetermination (adjustments & redetermination requests), maybe mailed or sent through the Provider Portal (faxed copies of requests are not accepted) to:

Dates of Service **prior** to 11/01/2019	Dates of Service **after** 11/01/2019
RightCare from Scott & White Health Plan Attn: Medicaid Appeals MS-A4-144 1206 West Campus Drive Temple, TX 76502	Scott and White Health Plan ATTN: RightCare PO Box 211342 Eagan, MN 55121-1342 Or https://rightcare.firstcare.com/Web/

REDETERMINATION REQUEST REQUIREMENTS

1. Providers may complete a Provider Claims Redetermination Request Form.
2. Provider should attach **any** pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records.
3. Requests for Redeterminations must be submitted within 120 days from the original determination date.
4. Processing time for redeterminations is 30 days from date of receipt.
5. This form should not be used for **CORRECTED CLAIMS**.

TEXAS STAR PROGRAM Your Health Plan ■ Your Choice

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

PROVIDER CLAIM REDETERMINATIN REQUEST FORM-MEDICAID

(This form should not be used for Commercial/Medicare claims)

In order to expedite the process of your request, this form may be used. Please complete all of the following information for each redetermination; if not completed, the correspondence will be returned to the provider for correction. Corrected claims are not accepted with this form.

Review Submission Date: _____ Contact Name: _____

Provider Name: _____ Contact Phone #: _____

Provider NPI #: _____ Member Name: _____

Provider Address: _____ Medicaid Member ID #: _____
_____

RightCare Claim #: _____ Date of Service: _____

Choose the Reason for Redetermination that best represents your request:

☐ Filing Limit
☐ Contracted Rate or Payment Policy
☐ Data Entry Error
☐ Overpayment/Underpayment: _____
☐ Claim Check/Code Editing
☐ COB
☐ TPI Update

☐ Other (specify): _____

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.

Dates of Service **prior** to 11/01/2019

RightCare from Scott & White Health Plan
Attn: Medicaid Appeals
MS-A4-144
1206 West Campus Drive
Temple, TX 76502

Dates of Service **after** 11/01/2019

Scott and White Health Plan
ATTN: RightCare
P.O. BOX 211342
Eagan, MN 55121-1342

TEXAS STAR PROGRAM Your Health Plan ■ Your Choice