

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

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 & White
PO Box 981727
El Paso, TX 79998-1727

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**.

PROVIDER CLAIM REDETERMINATION 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:

- | | |
|--|---|
| <input type="checkbox"/> Filing Limit | <input type="checkbox"/> Claim Check/Code Editing |
| <input type="checkbox"/> Contracted Rate or Payment Policy | <input type="checkbox"/> COB |
| <input type="checkbox"/> Data Entry Error | <input type="checkbox"/> TPI Update |
| <input type="checkbox"/> Overpayment/Underpayment: _____ | |
| <input type="checkbox"/> 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.

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