Adjustment & Appeal Communication Process

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

PROCESS FLOW:

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

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

2. Provider or inquiring party must provide the information on the "Provider Claims Appeal Request Form". **See attachment 1**
3. 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".
4. If the Claims Appeal Request Form or excel spreadsheet are not completed as requested above, it will be returned to the requestor for completion.
5. The "Claims Appeal Request Form" received by mail will be processed within 30 days of receipt.
6. As of April 16th all request for Adjustment or Appeal must be submitted using this format or the request will be returned.

SCOTT & WHITE HEALTH PLAN

The one Texans trust.

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**

☐ **Claim Check/Code Editing**

☐ **COB**

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

☐ **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.

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

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

All Claims request for adjustment must be submitted within 90 days from the date of payment or determination by SWHP to receive consideration. These considerations will be completed timely.