Claim Review Request

Please send one form and supporting documentation per claim for paper claim appeals to:
WellFirst Health, 1277 Deming Way, Madison, WI 53717

WellFirst Health®
provided by SSM Health Plan

PROVIDER CONTACT INFORMATION:

Date: _____

Provider Name: _____ **Tax ID Number:** _____

Contact Name: _____ **E-mail:** _____

Phone: _____

Submission Type: ◯ **First Request** ◯ **Subsequent Request (new documentation)**

MEMBER CONTACT INFORMATION:

Member Name: _____ **Member #:** _____

Claim Number: _____ **Date of Service:** _____

CODING REVIEW REQUEST:

Select the topic that best describes the denial received and submit a corrected claim if appropriate. When requesting a review of a denied code, please include a brief explanatory statement and supporting documentation.

Code Bundling	☐ CARC 234/RARC M15, CARC M20/RARC 16, CARC 97,150,231	**Maximum Units / Frequency of Service**	☐ CARC 151
New Patient Visit Denial	☐ CARC B16	**Invalid / Missing / Inappropriate Modifier**	☐ CARC 4
Qualifying Service Not Received	☐ CARC A1/RARC N122, CARC B15	**Global Surgery Denial**	☐ CARC 234/RARC M144 or N525
Assistant/Team/ Co-Surgeon	☐ CARC 54	**Diagnosis Denial**	☐ CARC 9, 11
Place Of Service Denial	☐ CARC 5	**Duplicate Denial**	☐ CARC 18
Non-Covered Procedure Denial	☐ CARC 96	**Unlisted / Miscellaneous / Code Denial**	☐ CARC 16/RARC N350, CARC 133

☐ **Other:** _____

NOTE: Patient weight required for review of drug denials: _____

Comments: _____

OTHER CORRECTION / REVIEW REQUEST:

◯ **Proof of Authorized Service (Include Auth#)** **Authorization #:** _____

◯ **Coordination of Benefits**

Other: _____