Eye Management

CLAIMS REVIEW/DISPUTE

FAX YOUR REQUEST TO (305) 861-2941

Please submit your dispute within thirty-five (35) days of your receipt of the Explanation of Benefits (EOB) or in accordance to applicable network health plan guidelines. Attach a copy of the claim and EOB under review/dispute. A separate form must be used for each patient and claim. The following section must be completed by the Physician's office:

Date of Request (mm/dd/yyyy)	Patient Last Name	Patient First Name
Patient Date of Birth (mm/dd/yyyy)	Health Plan	Patient ID

Provider Last Name	Provider First Name
Specialty	Date of Service (mm/dd/yyyy)

REVIEW/CHECK APPROPRIATE BOX

- ☐ Requesting reconsideration for denied services (inpatient or outpatient).
- ☐ Claim payment was denied for untimely filing. Additional information showing evidence of timely filing is attached.
- ☐ Claim payment was denied for lack of proper authorization. Additional information as addressed below must be attached to support your Review/Dispute.
- ☐ Claim was denied for eligibility
- ☐ Other (explain): _____

The following must be attached with your Review/Dispute. (If items are missing, the Review/Dispute will be denied without review):

☐ EOB/Adjustment ☐ Copy of claim, clearly marked "COPY"

The following may be attached with your Review/Dispute, if applicable. (If applicable item(s) is missing, the Review/Dispute will be denied without review.

☐ Medical Records ☐ Referral/Authorization ☐ Other:

THE FOLLOWING SECTION IS TO BE COMPLETED BY HN1/EMI:

Reviewer's Name	Date claim received (mm/dd/yyyy)	Date claim reviewed (mm/dd/yyyy)

CPT Code(s) Billed	CPT Code(s) Paid
Denial Code	Dx on Original Claim

OUTCOME

☐ Pay CPT Code(s)	☐ Deny (No further payment CPT Code(s)	☐ Denial Code(s)

Additional Comments