Review / Reopening Form

Today's Date

Should you wish to dispute a claim denial or claim payment amount, you may request a review of the claim by submitting a Review/Reopening Form. Please ensure this form is filled out in its entirety along with copies of all supporting documentation and mail to address below.

Mail To: iCare Medicare and iCare Medicaid
P. O. Box 660346
Dallas, TX 75266-0346

Type of Provider (select one)

- ○ Medicare Non-Contracted
- ○ Medicare Contracted
- ○ Medicaid Non-Contracted
- ○ Medicaid Contracted

Checklist of items required (If any item from the list is not included, submission may be delayed or dismissed)

- ☐ Explanation of Payment (EOP)
- ☐ Copy of Claim or Supporting Documentation

Provider Name: NPI: TIN:

Billing Address:

Contact Name: Contact Phone #:

Contact Address:

Member First Name: Member Last Name: iCare Member ID#: Member DOB:

Claim#: From Date of Service To Date of Service Billed Amount:

Reason given for denial (check all that apply)

- ☐ Authorization Denials
- ☐ Not Prior Authorized
- ☐ Benefit Denials
- ☐ Incidental / Mutually Exclusive/ Mutually Unlikely
- ☐ Other
- ☐ Timely Filing
- ☐ Out of Network
- ☐ Invalid Code

Reason For Request

Note: For Appeal information please refer to the iCare website and Provider Reference Manual.

Signature: Date: