



PO Box 7548
Rocky Mount, NC 27804

PROVIDER RECONSIDERATION & APPEAL FORM

Use this Provider Reconsideration and Appeal Form to request a review of a decision made Envolve Vision. The process for reconsideration and appeal is the same for participating and non-participating providers. Please see the Provider Manual for details and requirements of the reconsideration and appeal processes.

If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

All boxes immediately below are required to be completed – Do not attach another copy of the claim.

Provider Name	Provider Tax ID#												
Control/Claim Number <i>(Located on EOP)</i>	Date(s) of Service												
Member Name	Member ID Number												
Request Review Type (must select one): <input type="checkbox"/> Reconsideration (optional step) <input type="checkbox"/> Provider Appeal (required step to proceed to State Fair Hearing)													
Reason for Dispute (please check): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Claim was denied for no authorization, but authorization # _____ was obtained.</td> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Claim was paid to wrong provider.</td> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Retro eligibility.</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Claim was denied for no authorization, but no authorization is required for this service.</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Claim was denied for untimely filing in error (proof of timely filing should be attached).</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Coordination of benefits (please explain below).</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Claim was paid for incorrect amount.</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Client obligation/patient liability/spenddown not applied correctly.</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Denied as duplicate in error.</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Other (please explain below).</td> </tr> </table>		<input type="checkbox"/> Claim was denied for no authorization, but authorization # _____ was obtained.	<input type="checkbox"/> Claim was paid to wrong provider.	<input type="checkbox"/> Retro eligibility.	<input type="checkbox"/> Claim was denied for no authorization, but no authorization is required for this service.	<input type="checkbox"/> Claim was denied for untimely filing in error (proof of timely filing should be attached).	<input type="checkbox"/> Coordination of benefits (please explain below).		<input type="checkbox"/> Claim was paid for incorrect amount.	<input type="checkbox"/> Client obligation/patient liability/spenddown not applied correctly.		<input type="checkbox"/> Denied as duplicate in error.	<input type="checkbox"/> Other (please explain below).
<input type="checkbox"/> Claim was denied for no authorization, but authorization # _____ was obtained.	<input type="checkbox"/> Claim was paid to wrong provider.	<input type="checkbox"/> Retro eligibility.											
<input type="checkbox"/> Claim was denied for no authorization, but no authorization is required for this service.	<input type="checkbox"/> Claim was denied for untimely filing in error (proof of timely filing should be attached).	<input type="checkbox"/> Coordination of benefits (please explain below).											
	<input type="checkbox"/> Claim was paid for incorrect amount.	<input type="checkbox"/> Client obligation/patient liability/spenddown not applied correctly.											
	<input type="checkbox"/> Denied as duplicate in error.	<input type="checkbox"/> Other (please explain below).											
Supporting comments/explanation:													
Requestor Name:													
Date of Request:	Requestor Phone Number:												

ATTACH: A copy of the EOP with the claim number to be reviewed clearly circled. Please complete required information above and do not attach a copy of the claim. Mail completed form(s) and attachments to:

Envolve Vision
Attn.: Appeals / Reconsiderations
PO Box 7548
Rocky Mount, NC 27804

Or submit to the specialty partner address listed on your EOP.