



CLAIM CORRECTION/RECONSIDERATION FORM

MAIL TO:

Coventry Health Care of Nebraska, Inc.
Attn: Nebraska Reconsideration Team
PO Box 7797
London, Kentucky 40742

FROM:

Tele#

 Corrected Claim **Proof of Timely Filing** **Requested Information** **Request for Reconsideration****Member Name:** _____**Member ID Number:** _____**Date(s) of Service:** _____**Remittance Advice Date:** _____**Amount Billed:** _____**Amount Paid:** _____**Claim Number(s):** _____**This form is to be used ONLY for:**

- Submission of a standard claim correction
- Proof of timely filing for an **initial** untimely filing denial
- Response to CHC Nebraska regarding requests for additional information (i.e. ER notes, operative reports, primary carrier Explanation of Benefit/Remittance Advice, etc.)
- Submission of medical records **along** with a summary of why authorization was not obtained for services denied for no authorization

Please use the space below to supply any other necessary information, along with your attachment(s), to enable thorough reconsideration:

Signature of Sender

Date