Neighborhood Health Plan OF RHODE ISLAND™

CLAIM FORM FINDER

Please use this table to help determine which form to use.

REASON	FORM TO SUBMIT
Addition of information to the claim form	Corrected (Replacement)/Voided Claim Form
Adjustment of payment for over- or underpaid claim	Adjustment Request Form
Amended date of service	Corrected (Replacement)/Voided Claim Form
Amended original charge	Corrected (Replacement)/Voided Claim Form
Change(s) to, or voiding of, a previously processed claim	Corrected (Replacement)/Voided Claim Form
Coordination of Benefits (when *not designated* on original claim submission)	Corrected (Replacement)/Voided Claim Form
Coordination of Benefits (when designated on original claim submission, but EOB was not attached)	Adjustment Request Form
Correction of modifier, diagnosis or procedure code(s)	Corrected (Replacement)/Voided Claim Form
Disagreement with claim reconsideration	Provider Appeal Request Form
Duplicate claim	Adjustment Request Form
Incorrect payment or service denial, according to contract terms	Adjustment Request Form
MEDNT denial reason	Reconsideration Request Form
MNRQR or MUTEX denial reason	Reconsideration Request Form
NOPCP denials	Adjustment Request Form
PRNOT denial reason	Reconsideration Request Form
Retraction of payment	Adjustment Request Form
Submission of claim returned to sender for missing, invalid, or incomplete information	Only the red and white claim form is required, as this is considered a first-time submission.
Submission of patient record/additional information per NHPRI request	Reconsideration Request Form
Surgical global denials	Reconsideration Request Form
Timely filing limit exceeded	Provider Appeal Request Form
317 denial reason	Please use the additional codes and verbiage on the RA to determine, with this chart, which form to use

For reasons not listed here, or for any other questions regarding claim submission, please call Provider Claims Services at (401) 459-6080.

Corrected (Replacement) and Voided Claims

A Corrected (Replacement)/Voided Claim Request Form is used to submit a correction, such as a change in diagnosis code or date of service; to amend charges; or to add information, such as an NDC number, or to void a **previously processed** claim. A corrected or voided claim **replaces** the previously-submitted version of that claim.

- All corrected (replacement) and voided claims must be submitted on the appropriate **red and white claim form** with no handwritten elements, date stamps, correction fluid, or staples.
- All institutional claims (UB-04) must contain a corrected bill type, as well as the original claim number in Field 64.
- All professional claims (CMS-1500) must contain Resubmission Code "7" for a replacement claim, or an '8" for a voided claim, and the original claim number in Field 22.

Corrected Claim forms and accompanying documentation must be mailed to:

Neighborhood Health Plan of Rhode Island
PO Box 28259
Providence, RI 02908-3700

- Photocopies of claim forms, as well as forms that are handwritten, unclear, or missing information will be returned to the provider for revision and resubmission

Adjusted Claims

An Adjustment Request Form is used to request an adjustment, such as for coordination of benefits (when indicated as COB on the claim form, but the RA from the primary payer was not attached) or a payment retraction, to a previously processed claim.

- Adjustment requests must be made with a completed Adjustment Request Form, the affected claim number(s), and a Remittance Advice, Explanation of Benefits, and/or Coordination of Benefits documentation, as applicable.
- Adjustment Request forms and accompanying documentation must be mailed to:

  Neighborhood Health Plan of Rhode Island
  PO Box 28259
  Providence, RI 02908-3700
- Adjustment requests with *claims* attached will be returned to the sender.

Reconsiderations

A Claim Reconsideration Request Form is used to request reconsideration for payment on a previously processed claim.

- Resubmitted claims pertaining to Coordination of Benefits issues should NOT be remitted as Reconsideration requests.
- Reconsiderations must be made with a completed Claim Reconsideration Request Form, a copy of the applicable Remittance Advice, and encounter/physician and/or operative notes.
- Reconsideration forms and accompanying documentation may be:
  - Faxed to:
    (401) 709-7009, *or*
  - E-mailed securely to:
    Reconsideration@nhpri.org, *or*
  - Mailed to:
    Neighborhood Health Plan of Rhode Island
    PO Box 28259
    Providence, RI 02908-3700

Provider Appeals

A Provider Appeal Request Form is used to request an appeal for payment on a **previously denied** claim.

- Appeal requests must be made with a completed Provider Appeal Request Form, an appeal letter on office letterhead, a copy of the claim, and all supportive documentation, as applicable.
  - Appeals will not be accepted if any of this required information is missing.
- Appeal forms and accompanying documentation may be faxed to **(401) 709-7005** or mailed to:
  Neighborhood Health Plan of Rhode Island
  Attn: Grievance and Appeals Unit
  910 Douglas Pike
  Smithfield, RI 02917

Submission or resubmission of claims is not a guarantee of payment.