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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Reconsideration Request Form

Reconsideration #: ________________

Anything designated by an asterisk (*) is mandatory

Date Prepared: ____________________

* Form Prepared By: ______________________________ * Phone Number: ____________________
* Provider Name: ______________________________ * Provider Medicaid ID: ____________________
* Address Line 1: ____
* City: ______________________ * State: ______________ * Zip Code: ________________
* Email: ______________________________ * Fax Number: ____________________

* Reason for Reconsideration Request: ☐ Coding ☐ Improper Payments

Coding includes Place of Service, Modifiers, Diagnosis and Provider Type/Specialty Codes.
Improper Payments include claims that paid differently than expected.

EOB as listed on your Remittance Advice (number): ______________________________
* Most Recent ICN (Internal Control Number) of Denied Claim: ______________________________
* Recipient Name: ______________________________ * Recipient UID: ____________________
* Date(s) of Service – Begin Date: ______________________ End Date: ____________________
* Total Billed Amount of Claim: ________________ Log # or Agent Name: ____________________

Please do not staple the attachments to this completed form.

* Reconsideration request letter (required)
* Remittance Advices (RAs) (required)
* Claim form (required)
* Notes (required; exception to this rule are psychiatric services)

Claims history and denials
Coding Related Supporting Documentation

***** Internal Use Only *****

Gainwell Reviewer: ______________________________ Date Received: ____________________

Summary and Gainwell Recommendation:

DVHA Reviewer: ______________________________ Date Received: ____________________

Date Returned to Gainwell: ____________________

DVHA Decision/Outcome: ☐ Approved ☐ Denied ☐ Returned to process as normal claim

DVHA Summary and Recommendation:

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Instructions for Form Completion

****Note: This form is intended for non-timely filing reconsiderations only. Please use the appropriate form for Timely Filing Reconsiderations. Any timely filing reconsideration requests sent in on this form will be returned to the provider. This form is not intended to be used when submitting a corrected or adjusted claim. All inquiries not related to coding or improper payments need to be directed to the provider help desk.****

A request for review must be made no later than 90 calendar days after the Department of Vermont Health Access gives notice to the provider of its decision (**90 calendar days from the date of the Remittance Advice**). Requests made after 90 days will be returned with no action taken. Please save all completed forms for your records. After filling in the required information, save the document locally, print the form and mail it to **Gainwell Technologies, Attn: Administrative Review, PO Box 888, Williston, VT 05495**.

This form should be used when requesting a reconsideration of a non-timely filing denial or paid other than expected for one (1) claim. The following is an outline about how to complete this form. Providers (or those completed the form on the provider's behalf) are reminded that all asterisked fields are required. Failure to complete the required fields will result in the return of the request.

All coding-related reconsideration requests must have supporting documentation from a reputable source.

Date Prepared – This should reflect the date the form is being completed.
Form Prepared By – Input the name of the person completing the form.
Phone Number – Provide a phone number for the person completing the form in case of questions.
Mailing Address – Provide mailing address to which the approved or denied reconsideration request should be sent.
Email – Provide an email address in the case of questions.
Fax Number – Provide a fax number for sensitive materials that shouldn't be sent via email.
Reason for Reconsideration Request – Please select the reason that best represents the nature of the reconsideration you are requesting. The coding request type includes place of service codes, modifiers, diagnosis codes and provider type/specialty.
Most Recent ICN (Internal Control Number) of Denied Claim – Input the most recent ICN (Internal Control Number) of the denied claim.
Recipient Name – Input the Recipient's Name.
Recipient UID – Input the Recipient's Unique ID (UID).
Date(s) of Service – Input the earliest From Date on all the claim and the latest To Date on all the claim.
Total Billed Amount of Claim – Input the Total Billed Amount of the claim.
Log # or Provider Services Name – Log # of the call or the name of the representative spoken to regarding the issue.
Provider Name – Input the Billing Provider's Name.
Provider Number – Input the Billing Provider's Vermont Medicaid Number.
Attachments – Attachment options designated with an asterisk (*) are required for the request to be considered complete. The Reconsideration Request Letter, Notes, Remittance Advice(s) and a New Claim form (red & white CMS 1500/UB 04 or ADA Dental Claim Form) are required. Notes include but are not limited to office notes, operative notes, procedure notes, any notes that will aid in the decision making process. Remember you must NOT staple the attachments to this form.

Please note that your Reconsideration Request Letter must address the reason why your claim denied, along with an explanation of why you feel this denial needs review. Failure to provide this information will result in your request being returned to you.

Incomplete requests will be returned to the provider.