VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

State of Vermont - Department of Vermont Health Access (DVHA)

Timely Filing Reconsideration Form

Please do not staple attachments to this completed form

Please include a red & white claim form

Anything designated by an asterisk (*) is mandatory

Date Prepared

Form Prepared By: Contact Number:

*Provider Name *Provider Medicaid ID:

*Provider Return Mailing Address:

*Recipient Name: *Recipient UID:

Date(s) of Service: *Begin Date: *End Date:

*Total Billed Amount of Claim:

Original ICN (Internal Control Number)

Claim Adjusted: ☐Yes ☐No If Yes, adjustment date:

Medicare Primary Insurer?: ☐Yes ☐No If Yes, Date of Medicare Payment:

Please do not staple attachments to this completed form:

- ☐ *Appeal request letter
- ☐ *New Red & White Claim form
- ☐ Claim history and denials
- ☐ Remittance Advices (RAs)
- ☐ Account Notes (Not Medical Records)
- ☐ Other Insurance Attachments

FOR INTERNAL USE ONLY

Reviewed by Gainwell Technologies Employee (Please Print Name):

TO BE FILLED OUT BY DVHA

Final DVHA Recommendation:

Approved for Override: ☐Yes ☐No

Reviewed by DVHA Employee Date

Deputy Commissioner Date

Instructions for Completing the Timely Filing Reconsideration Form

This form can be downloaded to your computer for your convenience. It is a `locked' form; allowing you to fill in the required fields without altering the basic form. Please save all completed forms for your records.

After filling in the required information, save the document, print the form and mail it to Gainwell Technologies, PO Box 888, Williston, VT 05495.

This form should be used when requesting a reconsideration of a timely filing denial for one (1) claim. The following outlines how to complete this form. Providers (or those completing 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.

PAGE 1:

Date Prepared: This should reflect the date the form is being completed.

Form Prepared By: Please input the name of the person completing the form.

Contact Number: Provide a phone number for the person completing the form in case of questions.

* Provider Name: Input the Billing Provider's Name.

* Provider Return Mailing Address: Input the address you would like the timely filing reconsideration returned to.

* Provider Medicaid Number: Input the Billing Provider's Vermont Medicaid Number.

* Recipient Name: Input the Recipient's Name.

* Recipient UID: Input the Recipient's Unique ID (UID).

* Begin Date: Input the earliest From Date of the claim.

* End Date: Input the latest To Date of the claim.

* Total Billed Amt: Input the Total Billed Amount of the claim.

Original ICN (Internal Control Number): Input the Original ICN of the claim.

Claim Adjusted: Indicate if the original claim has been adjusted by checking the box adjacent to the appropriate answer and if Yes, input the date it was adjusted.

Medicare Primary Insurer?: Indicate if Medicare was the primary insurer associated with the claim by checking the box adjacent to the appropriate answer and if Yes, input the date of the Medicare payment.

* The Reconsideration Request Letter and a New Red & White Claim form are required.

Timely filing is only overridden when an extenuating circumstance beyond the provider's control prevented the claim from being filed timely or the provider can prove they were actively trying to resolve their claim denials.

A detailed explanation of the extenuating circumstance or follow-up activity should be clearly documented in your request letter.

Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not extenuating circumstances beyond the provider's control. Claim transmission errors, claims lost in the mail or claims that are continually resubmitted without addressing the denial do not constitute an override of a timely filing denial.