

Adjustment & Redetermination Request Communication Process

Below you will find the steps necessary to submit a claim for reprocessing (adjustments or redetermination requests).

PROCESS FLOW:

All Scott & White Health Plan (SWHP) claims submitted for redetermination (adjustments & redetermination requests), **except RightCare Medicaid Claims**, must be mailed. (faxed copies of requests are not accepted) to:

Scott and White Health Plan
ATTN: Provider Claims Redetermination Request
P.O. Box 21800
Eagan, MN 55121-0800

REDETERMINATION REQUEST REQUIREMENTS

1. Providers or inquiring parties will have only one (1) opportunity to submit a redetermination request on a claim. Multiple requests submitted on a single claim will not be processed and will be returned as “previously reviewed”.
2. Providers must complete a Provider Claims Redetermination Request Form, failure to do so will result the request being returned to the requestor for completion.
3. Provider should attach Any pertinent supporting documentation (i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records)
4. Requests for Redeterminations must be submitted within **90 days** from the original determination date. (120 days for Medicare Advantage Claims; 1 year for Out-of-State Providers)
5. Processing time for redeterminations is 30 days from date of receipt
6. Payment within 15 days of decision (45 days from date of receipt of request)
7. Verbal requests for a Redetermination do not have an associated TDI standard to complete the processing of the requested Redeterminations.
8. This form should not be used for CORRECTED CLAIMS. If a corrected claims needs to be submitted, please submit as a new claim to the below address:

Scott and White Health Plan
P.O. Box 21800
Eagan, MN 55121-0800



Provider Claim Redetermination Request Form
(This form should not be used for RightCare Medicaid claim appeals)

In order to expedite the process of your request, this form is required. **Please complete all of the following information for each redetermination; if not completed, the correspondence will be returned to the provider for correction.** Corrected claims are not accepted with this form. Please submit as a new claim to the below address.

Review Submission Date: _____	Contact Name: _____
Provider Name: _____	Contact Phone Number: _____
Provider NPI #: _____	Member Name: _____
Provider Address: _____	SWHP Member ID#: _____
SWHP Claim number: _____	Date Of Service: _____

Choose the Reason for Redetermination that best represents your request:

- | | |
|---|--|
| <input type="checkbox"/> Filing Limit | <input type="checkbox"/> Claim Check/Code Editing |
| <input type="checkbox"/> Contracted Rate or Payment Policy | <input type="checkbox"/> COB |
| <input type="checkbox"/> Data Entry Error | |
| <input type="checkbox"/> Overpayment/Underpayment (specify): _____ | |
| <input type="checkbox"/> Other (specify): _____ | |

Please attach any pertinent supporting documentation (i.e. surgical notes, office visit notes, pathology reports, and/or medical records) and mail it to the below address.

Scott and White Health Plan
P O Box 21800
Eagan, MN 55121-0800