

# Reconsideration Request

\*\*Form must be complete, or it will not be processed\*\*

THIS FORM IS ONLY APPLICABLE IF A CLAIM HAS BEEN PROCESSED AND A REMITTANCE ADVICE HAS BEEN ISSUED

Member's Name: _____	Patient's Name: _____
Member's ID Number: _____	Relationship: _____
BCBSNE Claim Number: _____	Date(s) of Service: _____
Provider Name: _____	Location of Services: _____
Individual NPI: _____	Clinic Tax ID or NPI: _____
Contact Name: _____	Address: _____
Phone Number: _____	Fax Number: _____

**Reconsideration:** A request to Blue Cross and Blue Shield of Nebraska to review a claim with additional information not previously provided.

If the denial is not listed below, the request may be considered an *appeal*; visit <https://www.nebraskablue.com/providers> to locate the *appeal form*.

Reason for Reconsideration (mark applicable box):

- Manufacturers Invoice for Pricing (attached)     Copy of Medical Records (attached)     Denied Timely Filing
- Other Insurance Information (attached)     High Dollar Prepayment Review
- Billing/Coding Dispute w/ Medical Rationale     Copy of Subrogation or Worker's Compensation

If the information on a processed claim is subsequently found to be incorrect or charges need to be added or voided, you must submit a corrected claim electronically.

Place a value of "5" (late charges), "7" (replacement of prior claim); or "8" (void/cancel of prior claim) in the 2300 CLM 05-03 element in the 837P file. Enter the original claim number assigned by BCBSNE in the 2300 REF\*8 segment of the 2300 loop.

If you are not able to file your corrected claim electronically because your claim will include attachments, your corrected paper claim must be filed to BCBSNE attached to THIS Reconsideration Request form.

Do not send only the claim with "corrected claim" or "replacement claim" written or typed on the claim itself, **it will be returned to resubmit with the form**. Submitting a new claim to replace one that has already been filed may result in a duplicate denial.

**PLEASE MAKE SURE TO COMPLETELY DESCRIBE WHY YOU ARE REQUESTING A RECONSIDERATION. VAGUE OR INCOMPLETE RESPONSES WILL DELAY OR POSSIBLY CAUSE A DENIAL OF YOUR REQUEST.**

Comments:

---



---



---



---

Please submit the reconsideration form to: Blue Cross and Blue Shield of Nebraska, Attention: HNR/Reimbursements, PO Box 3248, Omaha NE 68180-0001. Forms may also be faxed to 402-392-4153. For questions, please follow the process to check claim status on [Nebraskablue.com/providers](https://www.nebraskablue.com/providers).