

# Claim Review Request

Please send one form and supporting documentation per claim for paper claim appeals to:  
Prevea360 Health Plan, 1277 Deming Way, Madison, WI 53717



## PROVIDER CONTACT INFORMATION:

Date:

Provider Name:

Tax ID Number:

Contact Name:

E-mail:

Phone:

Submission Type:  First Request

Subsequent Request (new documentation)

## MEMBER CONTACT INFORMATION:

Member Name:

Member #:

Claim Number:

Date of Service:

## CODING REVIEW REQUEST:

Select the topic that best describes the denial received and submit a corrected claim if appropriate. When requesting a review of a denied code, please include a brief explanatory statement and supporting documentation.

<b>Code Bundling</b>	CARC 234/RARC M15, CARC M20/RARC 16, CARC 97,150,231	<b>Maximum Units / Frequency of Service</b>	CARC 151
<b>New Patient Visit Denial</b>	CARC B16	<b>Invalid / Missing / Inappropriate Modifier</b>	CARC 4
<b>Qualifying Service Not Received</b>	CARC A1/RARC N122, CARC B15	<b>Global Surgery Denial</b>	CARC 234/RARC M144 or N525
<b>Assistant/Team/ Co-Surgeon</b>	CARC 54	<b>Diagnosis Denial</b>	CARC 9, 11
<b>Place Of Service Denial</b>	CARC 5	<b>Duplicate Denial</b>	CARC 18
<b>Non-Covered Procedure Denial</b>	CARC 96	<b>Unlisted / Miscellaneous / Code Denial</b>	CARC 16/RARC N350, CARC 133
	<b>Other:</b>		

**NOTE: Patient weight required for review of drug denials:**

Comments:

## OTHER CORRECTION / REVIEW REQUEST:

Proof of Authorized Service (Include Auth#)

Authorization #:

Coordination of Benefits

Other: