Independent Review Provider Reconsideration Form

Please return completed form by mail or email to:

Mail:
Humana Healthy Horizons® in Louisiana
Attn: Independent Review
1 Galleria Blvd, Suite 1000
Metairie, LA 70001-2081

Email:
LAIndependentReviewRequest@humana.com

Mail to: ______________________________

Phone: ______________________ Email: ______________________

From: ______________________________

Required information

Member/recipient name:		
Member/recipient ID number:		
Date(s) of service:	Remittance advice date:	
Amount billed:	Amount paid:	Claim number:
Pended claim: Yes No		
Denial reason:	Denial code:	

Reason(s) for complaint:

Untimely filing	Claim recoupment error	Recoupment due to waste or abuse
Medical necessity	Neither paid nor denied	Lack of authorization
Level of care	Claim paid incorrectly	Other; Explain: ______________

To request reconsideration, providers have 180 days from the date a claim denied in whole, partially or recoupment date of a claim or the managed care organization (MCO) failed to issue a remittance advice within 60 calendar days. Please use the space below to provide reason for dispute and any other necessary information, along with your attachments, to enable a thorough reconsideration.

Signature: Date:

Note: The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with **R.S. 46.460.81**, within 5 calendar days after the receipt of the request, and render a final decision by providing a response to the provider within 45 calendar days from the date of the receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

Humana Healthy Horizons® in Louisiana

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