ADJUSTMENT AND REDETERMINATION REQUEST COMMUNICATION PROCESS-MEDICAID

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

Process Flow

All FirstCare Medicaid claims submitted for redetermination (adjustments and redetermination requests), may be mailed or sent through the Provider Portal (faxed copies of requests are not accepted).

Mailing Address
FirstCare Health Plans
ATTN: Provider Claims Redetermination Request
PO Box 211342
Eagan, MN 55121-1342

Provider Portal
my.FirstCare.com

1. Providers may complete a Provider Claims Redetermination Request Form.
2. 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.
3. Requests for Redeterminations must be submitted within 120 days from the original determination date.
4. Processing time for redeterminations is 30 days from date of receipt.
5. This form should not be used for **corrected claims**. If a corrected claim needs to be submitted, please submit as a new claim to the above address.

FirstCare HEALTH PLANS
PART OF BAYLOR SCOTT & WHITE HEALTH

PROVIDER CLAIM REDETERMINATION REQUEST FORM-MEDICAID

(This form should not be used for Commercial/Medicare claims)

In order to expedite the process of your request, this form may be used. 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.

Review Submission Date: _____ Contact Name: _____

Provider Name: _____ Contact Phone #: _____

Provider NPI #: _____ Member Name: _____

Provider Address: _____ Medicaid Member ID #: _____

_____

FirstCare Claim #: _____ Date of Service: _____

Choose the reason for Redetermination that best represents your request:

☐ Filing Limit
☐ Contracted Rate or Payment Policy
☐ Data Entry Error
☐ Claim Check/Code Editing
☐ COB
☐ TPI Update

☐ Overpayment/Underpayment: _____

☐ 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 following address:

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Attn: Provider Claims Redetermination Request
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