SENIOR Preferred (HMO)

Senior Preferred Reopening Request Form

Please send completed form to:
Quartz, Attn: Senior Preferred Claim Recoveries Department
840 Carolina Street
Sauk City, WI 53583

Senior Preferred (HMO)
840 Carolina Street • Sauk City, WI 53583
(800) 394-5566 • Fax (608) 643-2564 • TTY 711

Provider Contact Information

Provider Name:

Date of Reopening Request:

Contact Name:

Provider TIN Number:

Phone: (   )

Provider Address:

City:

State:

ZIP:

Member Information

Member Name:

Member ID #:

Claim Number:

Patient Account #:

Date of Service

Senior Preferred (HMO) reopenings are written requests to fix an error on previous claim determinations and must meet all of the following requirements –

- May result in either an overpayment or underpayment.
- Are past the timely filing limit of one year from the date of service.
- Are submitted within two years from the initial determinate date (original claim processed date).

If the claim meets all of the requirements above, and the timeframe is within two to four years from the initial determination date, then please provide documentation of good cause. Documentation is necessary to considerer the reopening request. Reopenings may take up to 60 days to process. Please do not send additional requests until the initial request is finalized.

Important Note: Reopenings, claim adjustments and coding denial appeals are different processes. If you have a *claim adjustment*, please complete a Claim Adjustment Form. If you have a *coding denial appeal,* please complete a Coding Denial Appeal Form.

Please list the specific reason for the reopening request below. **Note: a statement of dissatisfaction is not grounds for reopening.**

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If the reopening request is within two to four years from the initial determination date, then please provide justification of good cause below.

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More information about the Senior Preferred Reopening Request Form

When and how to initiate reopening

If a claim needs correction past the initial timely filing limit of one year from the date of service, you must use the Reopening Request form.

Reopenings are written requests to fix an error on a previous claim determination that can result in either an overpayment or an underpayment. The Reopening Request form should include supporting documentation. A reopening can be initiated by the provider or by the plan.

Reopenings are different from adjustments.

Adjustment bills must be filed within one year of the date of service. Reopening can be filed if –

- The time frame is greater than one year from the date of service and less than two years from the initial determination date (original claim processed date) for any reason; or
- within two to four years of the initial claim determination date upon showing good cause, and
- the claims director approves the reopening request.

When NOT to initiate reopening

Reopening requests are not appropriate for –

- Response to a claim denial from a review of medical records
- An itemization bill or
- A coding appeal.

This includes failure to submit medical records, itemization, etc. in response to a request for additional information. Providers must submit an appeal request for such denials.

Helpful Tips:

- Reopening requests received with invalid or inaccurate information cannot be processed and will be returned with a system-generated letter.
- Inquiries will not be accepted if sent as a Reopening. Examples of “inquiries” include –
  - Asking for the status of claims or Reopening requests previously submitted.
  - Questions regarding denied and / or rejected claims.
  - Questions about the amount paid on processed claims.
- Requests to reprocess previously submitted claims without identifying specific error or changes needed.
- Do not submit duplicate requests.
- Check for accuracy PRIOR to submitting the form to avoid errors.
- If erroneous reopenings are submitted, do not resubmit corrections until the initial request is finalized.
- Reopenings may take up to 60 days to process. Do not send “second” and “third” requests.