Provider Claim Redetermination / Reconsideration Request Instructions

Please read the following information carefully to ensure a timely and thorough redetermination / reconsideration review. A detailed description of the request and supporting documentation is required. Include the authorization number if an authorization is associated with the request.

CLAIMS RELATED TO NO AUTHORIZATION

Redetermination / reconsideration requests related to no authorization will only be considered in the following circumstances:

□ The eligibility of the member was in a pending status at the time of service.

□ The member's eligibility was updated retroactively.

□ The provider and/or member was unaware that the member was eligible for services at the time that services were rendered.

□ A catastrophic event occurred that substantially interfered with the normal business operations of a provider.

Be sure to include (as applicable) chart notes, operative reports, office visit notes, billing statement, manufacturer invoice, inpatient progress notes or other documentation that supports the circumstances listed above.

CLAIMS WITH AN APPROVED AUTHORIZATION

Requests with an approved authorization will be considered if a detailed description of the issue is provided. Discrepancies related to diagnosis code, procedure/modifier code, place of service, number of units and dates of service will be considered.

SUBMISSION

Submit the completed form and attachments to:

For Medicare:

Trillium Medicare Advantage
Attn: Reconsiderations
PO Box 4000
Farmington, MO 63640-4400

For Oregon Health Plan (OHP):

Trillium Community Health Plan
Attn: Redeterminations
PO Box 5030
Farmington, MO 63640-5030

QUESTIONS

For assistance or questions about the redetermination / reconsideration process, contact Trillium Community Health Plan Monday through Friday 8am to 5pm. For Medicare plans, call (844) 867-1156 or (541) 431-1950. For Oregon Health Plan (OHP), call (877) 600-5472 or (541) 485-2155.

Provider Claim Redetermination / Reconsideration Request Form

PROVIDER INFORMATION

Provider Name: _____ Today's Date: _____

Provider Number (NPI or TIN): _____ Contact Phone: _____

CLAIM INFORMATION

Member Name: _____ Member ID: _____

Claim Number(s): _____

Date(s) of Service: _____

Service(s) Denied: _____

REASON FOR REDETERMINATION / RECONSIDERATION REQUEST

Is there an authorization associated with this claim?

☐ Yes. Authorization # _____

There is an issue with:

□ Diagnosis code
□ Place of service
□ Billed / allowed amount
□ Number of units
□ Dates of service
□ Procedure code / modifier
□ Timely Filing

☐ No.

No authorization was obtained because:

□ No authorization was required
□ Member eligibility issue
□ Catastrophic event
□ Authorization was attempted

Detailed Description of Request: [See instructions for supporting documentation requirements]

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