

Claim Payment Appeal Submission Form

Washington | Medicaid

Member information

Member first/last name:	
Member ID:	
Member DOB:	

Provider/provider representative information

Provider first/last name:			
NPI number:			
Provider street address:			
City:	State:	ZIP code:	
<input type="checkbox"/> I am a participating provider.		<input type="checkbox"/> I am not a participating provider.	
Provider representative:	<input type="checkbox"/> Self <input type="checkbox"/> Billing agency <input type="checkbox"/> Law firm <input type="checkbox"/> Other: _____		
Representative contact name:			
Contact phone:			
Email:			
Street address:			
City:	State:	ZIP code:	

Claim information

Claim number:	
Billed amount:	\$
Amount received:	\$
Start date of service:	
End date of service:	
Authorization number:	

** For multiple claims related to the same issue, providers can use one form and attach a listing of the claims with each supporting document. **This form is a required attachment for all claim payment appeals.**

Claim payment appeal

All claim payment appeals must be submitted in writing or via our provider website. We accept web and written payment claim payment appeals within 60 calendar days of the date the *Reconsideration Determination* letter was mailed. A claim payment appeal is defined as a request from a healthcare provider to change a decision made by Wellpoint related to a claim payment for

provider.wellpoint.com/wa

Coverage provided by Wellpoint Washington, Inc.

Wellpoint Washington, Inc. profoundly acknowledges and respects the inherent sovereignty of the federally recognized tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the tribes, a bond reiterated by the *Centennial Accord* and established by *RCW 43.376*. We heartily commit to enhancing our coordination, collaboration, and communication with tribal health programs and providers. Our activities are driven by an intent of respect, understanding, and recognition of the deeply rooted traditions and values of the tribal communities.

services already provided. A provider claim payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a *Notice of Action*.

Claim payment reconsideration reference number:	
---	--

Reason for claim payment appeal

To ensure timely and accurate processing of your request, please mark the applicable determination provided on the *EOP*.

<input type="checkbox"/> Untimely filing <input type="checkbox"/> No authorization <input type="checkbox"/> Denied for other health insurance (OHI) but member does not have OHI <input type="checkbox"/> Experimental/investigational procedure denial	<input type="checkbox"/> Claim code editing denial <input type="checkbox"/> Retrospective authorization issue <input type="checkbox"/> Disagree that you were paid according to contract <input type="checkbox"/> Data elements on the claim on file do not match the claim originally submitted	<input type="checkbox"/> Denied as duplicate <input type="checkbox"/> Denial related to provider date issue <input type="checkbox"/> Member retro-eligibility issues <input type="checkbox"/> ER level of payment review <input type="checkbox"/> Other
--	---	---

Mail this form (or upload if filing a web claim payment appeal), a listing of claims (if applicable), and supporting documentation to:

Payment Dispute Unit
Wellpoint Washington, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599