HEALTH TRADITION P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

Claim Resubmission Request Form

Original claims should be submitted electronically or by mail. This form is required for "resubmission(s) only". Charges denied as non-covered services should not be submitted using this form. This form is required when submitting a claim for the following reasons:

- Corrected claim
- Claim adjustment

This form serves as the fax cover letter for all applicable claims.

Please complete all applicable fields:

Date requested: _____

Claim #: _____

Date of service: _____

Patient name: _____

Member ID#: _____

Billed amount: _____

Tax ID#: _____

NPI#: _____

Provider name: _____

Contact name: _____

Contact phone: _____

Contact e mail: _____

Contact fax: _____

Check all applicable boxes below to describe the reason for your request.
A corrected CMS-1500/UB-04 is required for the bolded reason(s).

- ☐ **Late charges**
- ☐ Timely filing denial**
- ☐ **Incorrect date of service**
- ☐ **Corrected location**
- ☐ Resubmitted with primary EOP
- ☐ **Added/revised 1st modifier***
- ☐ **Added/revised 2nd modifier***
- ☐ **Denied as duplicate in error***
- ☐ **Incorrect provider**
- ☐ **Incorrect procedure code***
- ☐ **Incorrect amount billed**
- ☐ **Incorrect patient billed**
- ☐ **Incorrect diagnosis code***
- ☐ Disputed payment/contract discount
- ☐ **Removed charges**
- ☐ Other-please explain; be specific:
- ☐ Provider appeal*

Medical Records Required

**A timely filing denial requires proof of original submission or proof of insurance notification. Proof of Original Submission:

Electronic Claims: Include a copy of the WEA Trust Claims Acknowledgement Report showing receipt of a clean claim submission within the timely filing limits under your Provider Agreement.
Paper Claims: Include a copy of a screen print from your accounting software to show the date you submitted the claim. The accounting software Information must also include proof that the claim is for the correct patient and the correct date of service.

Proof of Insurance Notification:

Include a copy of a screen print from your accounting software to show the date of notification of insurance coverage. The accounting software Information must also include proof that the claim is for the correct patient and the correct date of service.

Please submit this form with the additional necessary documents.

Fax: 608.276.9119

Mail: Health Tradition Health Plan
ATTN: Claims Resubmission Request
PO Box 21171
Eagan, MN 55121