BAYLOR SCOTT & WHITE HEALTH PLAN-COMMERCIAL/MEDICARE ADJUSTMENT & REDETERMINATION REQUEST COMMUNICATION PROCESS

Below you will find the steps necessary to submit a claim for reprocessing (adjustments or redetermination requests). For Commercial Claims, provider should contact our Claim Review Line to submit a redetermination at 833.542.8179.

PROCESS FLOW:

All Baylor Scott & White Health Plan (BSWHP) claims submitted for redetermination (adjustments & redetermination requests), **except RightCare Medicaid Claims,** must be mailed or sent through the Provider Portal (faxed copies of requests are not accepted) to:

Baylor Scott & White Health Plan
ATTN: Provider Claims Redetermination Request
P.O. Box 211342
Eagan, MN 55121-1342

BSWHealthPlan.com/Pages/ProviderPortal.aspx

REDETERMINATION REQUEST REQUIREMENTS

1. Providers or inquiring parties will have only one (1) opportunity to submit a redetermination request on a claim. Multiple requests submitted on a single claim will not be processed and will be returned as "previously reviewed".
2. Providers must complete a Provider Claims Redetermination Request Form, failure to do so will result the request being returned to the requestor for completion.
3. Provider should attach any pertinent supporting documentation (i.e. proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records.
4. Requests for Redeterminations must be submitted within **90 days** from the original determination date. (120 days for Medicare Advantage Claims; 1 year for Out-of-State Providers).
5. Processing time for redeterminations is 30 days from date of receipt.
6. Payment within 15 days of decision (45 days from date of receipt of request).
7. Verbal requests for a Redetermination do not have an associated TDI standard to complete the processing of the requested Redeterminations.
8. This form should not be used for **CORRECTED CLAIMS**.

Baylor Scott & White Health Plan

PROVIDER CLAIM REDETERMINATION REQUEST FORM- COMMERCIAL/MEDICARE

(This form should not be used for RightCare Medicaid 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: _____ Member ID #: _____

_____

SWHP Claim #: _____ Date of Service: _____

Choose the Reason for Redetermination that best represents your request:

☐ Filing Limit ☐ Claim Check/Code Editing

☐ Contracted Rate or Payment Policy ☐ COB

☐ Data Entry Error

☐ 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 below address.

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