Harvard Pilgrim Health Care

a Point32Health company

Stride[SM] (HMO)/(HMO-POS) Medicare Advantage *Claim Review Form*

Instructions

NOTE: This form is only for Requests for Claim Reviews. If you would like to appeal a plan decision regarding coverage, please follow the Provider Appeal Process and submit using the *Provider Appeal Form* which can be found at *www.harvardpilgrim.org/providers/stride.* Mail completed **Appeal Form** and attachments to:

Medicare Advantage Provider Appeals
P.O. Box 690546
Quincy, MA 02269

Issues managed through the Claim Review process include clarifications such as reasons for coding decisions or other extenuating circumstances, requests regarding processing or pricing, requests for payment retractions and other similar requests. It is not necessary to utilize the Claim Review process for corrected claims or responses to requests for additional information. Resubmissions and responses to requests for additional information can be submitted directly to:

Harvard Pilgrim Health Care, Inc.
c/o Stride Claims Processing
P.O. Box 211067
Eagan, MN 55121

If you have any questions regarding these processes please call Harvard Pilgrim Health Care Stride Provider Services at 888-609-0692.

Please complete all information requested. Incomplete submissions will be returned unprocessed. Submit the completed **Claim Review Form** with all supporting documentation to:

Harvard Pilgrim Health Care, Inc.
c/o Stride Claims Processing
P.O. Box 211067
Eagan, MN 55121

Today's Date (MM/DD/YYYY):

Provider Information

Provider name:	NPI:
Submitter name:	Contact phone:
Submitter address:	

Member/Claim Information

Member name:	Member ID:
Claim number:	Date(s) of service:

Review Type — Check one box, and/or provide comment below to reflect purpose of request for review.

- ☐ **Coordination of Benefits:** Initial claim submission could not fully be processed until information from another insurer was received.
- ☐ **Corrected Claim:** The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made.
- ☐ **Duplicate Claim:** The original submission was denied as a duplicate claim.
- ☐ **Missing Authorization or Referral Information:** The referral or authorization number was not included on the initial submission.
- ☐ **Retraction of Payment:** The provider is requesting a retraction of the entire payment or service line (e.g., not your patient, service not performed, etc.).
- ☐ **Other** (please explain)**:**

Clear Form