# PAR PROVIDER PAYMENT RECONSIDERATION FORM

Date: _____

**Please complete the following form to help expedite the review of your claims reconsideration.**

***** Is this a

- ☐ **Request for Reconsideration:** you disagree with the original claim outcome (payment amount, denial reason, etc.) Please check if this is the first time you are asking for a review of the claim.
- ☐ **Claim Dispute:** you disagree with the outcome of the Request for Reconsideration

| **Provider Name*** | **Provider Tax ID*** |
|---|---|
| **Provider NPI*** | **Date of Last Explanation of Payment** |
| **Sunflower Health Plan Claim Number*** | **Date of Service*** |
| **Member Name** | **Member ID** |

* Indicates a required field

Reason for the reconsideration (please check all that apply):

- ☐ Claim was denied for no authorization, but authorization number was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for Member not eligible, but member was eligible on DOS (attach eligibility information)
- ☐ Claim was denied for incomplete or missing sterilization form, but one was submitted with claim (attach completed form)
- ☐ Claim was not paid per the terms of my contract with Sunflower Health Plan (attach relevant reimbursement section) Claim was denied “Past Timely Filing” (attach proof of timely filing)
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information Other: Please explain

Please ensure sufficient detail is provided to assist us in the review of your reconsideration or dispute. Mail completed forms and all attachments to:

**Sunflower Health Plan**
**Claims Reconsiderations & Disputes Department**
**PO Box 3060**
**Farmington, Missouri 63640-3800**

Contact name & number of person requesting the appeal _____