Provider Claims Reconsideration Form

If you are submitting a claim for reconsideration, please complete this form. You will need to print it and send it to the appropriate address noted on the second page of this form.

Please include all documentation with this form, including OHI EOBs, proof of timely filing to another payer, claim forms, claim rejection letter, and any other information relevant to support your request for reconsideration. Attach additional pages/spreadsheet if needed.

Important: Incomplete or missing information or forms could result in a denial of reconsideration.
Only requests submitted with credible reasons will be considered.

CCN: ☐ PC3: ☐

Reason for Provider Reconsideration Request (check one):

Authorization: ☐ Pricing: ☐ Timely Filing: ☐ Other (please specify on page 2) : ☐

Date of Reconsideration Request: _____

Provider Information

Provider Name: _____

National Provider Identifier (NPI): _____ Tax Identification Number (TIN): _____

Billing Street Address: _____

City: _____ State: _____ Zip: _____

Provider Contact Information

Provider Contact Name: _____

Contact Phone: _____ Contact Email: _____

Check if the same as Billing Address: ☐ Address: _____

City: _____ State: _____ Zip: _____

Veteran Information

Last Name: _____ First Name: _____

EDIPI or last four of SSN: _____ Date of Birth: _____

Claim Information

VA Authorization Number (if available): _____ Authorization Validity Dates: _____

VAMC (if available): _____ Claim Number: _____

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Reconsideration Request Explanation

Please provide details to support your request for reconsideration of your claim(s). Use a separate page if required.

Submission Process

Complete and print the form.

Mail to: TriWest Claims
P.O. Box 42270
Phoenix, AZ 85080-2270

Questions? Contact (877) 226-8749

*Reconsideration review may take 30-45 days.
Upon completion, approved requests will be paid.
Denied requests will receive written notification.