

Part A Provider Assistance Request Form

<input type="checkbox"/>	<p>Medical Review Additional Development Request (ADR) Must be returned in 30 days.</p> <p>Note: Required medical documentation should be submitted with a copy of the Medical Review ADR. This address should only be used when medical documentation is requested.</p>	<p>CO, NM, OK, TX Part A Medical Review P.O. Box 650095 Dallas, TX 75265-0095</p>
<input type="checkbox"/>	<p>Redetermination Request* (Appeal)</p> <p>Note: A redetermination can only be requested if a claim has been processed with medically denied services and the provider is dissatisfied with the determination rendered on the claim. The complete medical record must be submitted with the redetermination request.</p> <p>Must complete before submitting redetermination request: Specific service(s) and/or item(s) pertaining to the redetermination request: _____</p>	<p>CO, NM, TX Part A Redeterminations P.O. Box 660155 Dallas, TX 75266-0155</p> <p>OK Part A Redeterminations P.O. Box 650713 Dallas, TX 75265-0713</p>
<input type="checkbox"/>	<p>Reconsideration Request* (Hearing)</p> <p>Note: Reconsideration requests are processed by the QIC.</p>	<p>MAXIMUS Federal Services QIC Part A East 1040 First Avenue, Suite 400 King of Prussia, PA 19406</p>
<input type="checkbox"/>	<p>Claims Reopening Request</p> <ol style="list-style-type: none"> 1. A claim has medically denied charges. The provider does not disagree with the denied charges, but needs to add or remove charges that have not been medically denied without adding an additional diagnosis. No changes to the amount of the medically denied charges will be allowed, and the medically denied charges cannot be removed. 2. Adding occurrence code 32 and/or modifier GA to indicate an Advance Beneficiary Notice of Noncoverage (ABN) was given for services previously denied as provider liable. The ABN must be submitted with the adjustment request. 3. Requesting a cancel on a claim with medically denied charges. Valid reasons to request a cancel: <ol style="list-style-type: none"> a. Claim processed under an incorrect National Provider Identifier (NPI) or Provider Transaction Access Number (PTAN). b. Claim processed under an incorrect Health Insurance Claim (HIC) number. c. Outpatient claim that should be combined with an inpatient claim. d. Note: Cancellation requests for reasons other than those listed above should be indicated in the Remarks field (FL80) of the UB-04. 	<p>CO, NM, TX Part A Claims P.O. Box 660030 Dallas, TX 75266-0030</p> <p>OK Part A Claims P.O. Box 650712 Dallas, TX 75265-0712</p>

	A valid UB-04 adjustment (TOB XX7) or cancel (TOB XX8) request must be included. Non-covered charges should be reported with services that were medically denied on the original claim.	
<input type="checkbox"/>	UB-04 Claims/Adjustments/Voids/ADRs Note: Claims, adjustments and voids can be submitted electronically. Please indicate in the comments field below the reason for filing a paper claim request. Note: A completed UB-04 claim form must be included with each request. Claims documentation such as clarification of the NPI or legacy number should be submitted with a copy of the Claims ADR.	CO, NM, TX Part A Claims P.O. Box 660030 Dallas, TX 75266-0030 OK Part A Claims P.O. Box 650712 Dallas, TX 75265-0712
<input type="checkbox"/>	Routine Written Inquiries (Billing, claims-related issues and policy)	CO, NM, TX Part A Written Inquiries P.O. Box 660155 Dallas, TX 75266-0155 OK Part A Written Inquiries P.O. Box 650713 Dallas, TX 75265-0713

*Signature _____ Date _____
 (*Signature is required.)

Certified mail and documents sent via commercial courier must be sent to TrailBlazer's physical address below. To ensure proper delivery, information sent to the physical address **must** include "ATTN: Department Name."

TrailBlazer Health Enterprises, LLC
ATTN: <Department Name>
Executive Center III
8330 LBJ Freeway
Dallas, TX 75243-1213

Please ensure the following information appears with every written request:

Provider Name _____
 CMS PTAN _____ NPI _____
 HIC Number _____
 Beneficiary Name _____
 Claim Date(s) of Service _____
 Document Control Number (DCN) _____
 Comments _____