



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 submitting requested medical documentation.</p>	<p>CO, NM, OK, TX Part A Medical Review P.O. Box 650095 Dallas, TX 75265-0095</p> <p>J4901 Part A Medical Review P.O. Box 660389 Dallas, TX 75266-0389</p>
<input type="checkbox"/>	<p>Medical Review Reopening Request/Request for Redetermination for Non-Receipt of Records</p> <p>Note: A medical review reopening can only be requested if a claim has been denied with reason code 56900 (not reasonable and necessary based on non-receipt of the documentation). Required medical documentation as defined in the ADR should be submitted with a copy of the ADR.</p>	<p>CO, NM, OK, TX Part A Medical Review Reopenings P.O. Box 650095 Dallas, TX 75265-0095</p> <p>J4901 Part A Medical Review P.O. Box 660389 Dallas, TX 75266-0389</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:</p> <p>Specific service(s) and/or item(s) pertaining to the redetermination request:</p> <p>_____</p> <p>_____</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> <p>J4901 Part A Redeterminations P.O. Box 660371 Dallas, TX 75266-0371</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. The medically denied charges cannot be removed. 2. 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) 	<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>

	<p>number.</p> <p>c. Outpatient claim that should be combined with an inpatient claim. Note: Cancellation requests for reasons other than those listed above should be indicated in the Remarks field (FL 80) of the UB-04.</p> <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.</p>	<p>J4901 Part A Claims P.O. Box 660282 Dallas, TX 75266-0282</p>
<input type="checkbox"/>	<p>UB-04 Claims/Adjustments/Voids/ADRs</p> <ul style="list-style-type: none"> • Claims, adjustments and voids can be submitted electronically. Please indicate in the comments field below the reason for filing a paper claim request. • 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. 	<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> <p>J4901 Part A Claims P.O. Box 660282 Dallas, TX 75266-0282</p>
	<p>Routine Written Inquiries</p> <p>Please complete and submit the J4 Written Inquiry Form for general inquiries related to billing, claims-related issues and policy: http://www.trailblazerhealth.com/Publications/PDF/Form/J4GeneralInquiryForm.pdf</p>	

*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 _____