



Claim Resubmission Request Form

Original claims should be submitted electronically or by mail. This form is required for "resubmission(s) only".

Charges denied as non-covered services should not be submitted using this form. This form is required when submitting a claim for the following reasons:

- Corrected claim
- Claim adjustment

This form serves as the fax cover letter for all applicable claims.

Please complete all applicable fields:

Date requested: _____	Tax ID#: _____
Claim #: _____	NPI#: _____
Date of service: _____	Provider name: _____
Patient name: _____	Contact name: _____
Member ID#: _____	Contact phone: _____
Billed Amount: _____	Contact Email: _____

Check all applicable boxes below to describe the reason for your request.

A corrected CMS-1500/UB-04 is required for the bolded reason(s).

- | | |
|--|---|
| <input type="checkbox"/> Late charges | <input type="checkbox"/> Incorrect provider |
| <input type="checkbox"/> Timely filing denial** | <input type="checkbox"/> Incorrect procedure code* |
| <input type="checkbox"/> Incorrect date of service | <input type="checkbox"/> Incorrect amount billed |
| <input type="checkbox"/> Corrected location | <input type="checkbox"/> Incorrect patient billed |
| <input type="checkbox"/> Resubmitted with primary EOP | <input type="checkbox"/> Incorrect diagnosis code* |
| <input type="checkbox"/> Added/revised 1st modifier* | <input type="checkbox"/> Disputed payment/contract discount |
| <input type="checkbox"/> Added/revised 2nd modifier* | <input type="checkbox"/> Removed charges |
| <input type="checkbox"/> Denied as duplicate in error* | <input type="checkbox"/> Other - please explain; be specific: |

***Medical records required**

**** A timely filing denial requires proof of original submission or proof of insurance notification.**

Proof of Original Submission:

Electronic Claims: Include a copy of the WEA Trust Claims Acknowledgement Report showing receipt of a clean claim submission within the timely filing limits under your Provider Agreement.

Paper Claims: Include a copy of a screen print from your accounting software to show the date you submitted the claim. The accounting software Information must also include proof that the claim is for the correct patient and the correct date of service.

Proof of Insurance Notification:

Include a copy of a screen print from your accounting software to show the date of notification of insurance coverage. The accounting software Information must also include proof that the claim is for the correct patient and the correct date of service.

Please submit this form with the additional necessary documents.

Fax: 608.276.9119

Mail: WEA Trust Insurance
ATTN: Claims Resubmission Request
PO BOX 8220
Madison, WI 53708-8220

If you have any questions, please call Customer Service at 800.279.4090.

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