

RESUBMISSION

Please complete this form and return one for each claim resubmission.

Please select the appropriate plan:

MCCC MCA Mercy RBHA MCLTC DD DCS CHP

Date of Resubmission:	
Member Name:	
Provider NPI #:	
Provider Tax ID #:	
Original Claim Number:	
Date of Service:	
Resubmission Reason:	

Use the checklist below to help with correct claim processing

Did you remember to use a new claim form?

Did you remember to stamp the top of the claim form as "Resubmission"?

Did you remember to make sure all of the information from your original claim form is included on the new claim form, only changing/updating the information that was either missing or incorrect?

Did you remember to include a copy of the Remittance Advice from the original claim that was denied or paid incorrectly?

Did you remember to include any additional required documentation to process the claim (i.e. medical records, etc.)?

Did you remember to include a Share of Cost (SOC) letter from AHCCCS for ALTCS members, if applicable?

Did you remember that this Cover Letter should be the first page of your resubmission paperwork?

Acknowledgement

I acknowledge that this resubmission is NOT a claims dispute or appeal.

PLEASE MAIL ALL RESUBMISSION REQUESTS TO:

MERCY CARE COMPLETE CARE MERCY CARE ADVANTAGE Medical Claims Attn: Resubmissions P.O. Box 982975 El Paso, TX 79998-2975	MERCY CARE RBHA Medical Claims Attn: Resubmissions P.O. Box 982976 El Paso TX 79998-2976	MERCY CARE RBHA Dental Claims Attn: Resubmissions P.O. Box 982977 El Paso, TX 79998-2977	AETNA MEDICAID ADMINISTRATORS, LLC FAMILY PLANNING Family Planning Claims Attn: Resubmissions P.O. Box 982978 El Paso, TX 79998-2978
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