

Provider Bulletin

Subject:	Request for Claims Review		
Plan:	All Plans	Bulletin Date:	December 31, 2015
Bulletin Number:	15-014	Effective Date:	Immediately

This bulletin is to update providers regarding the submission of Request for Claims Review.

Providers may request a review of a claim decision by completing a Request for Review Form located on our website <http://www.hcdpbc.org/Modules/ShowDocument2.aspx?documentid=1254>.

The provider is responsible for submitting all necessary information to re-evaluate the reimbursement decision.

Requests for review must be filed within 45 days from the date of Remittance Advice. Forms and supporting documentation may be faxed to (561) 671-4664 or mailed to the following address:

Health Care District of Palm Beach County
Attn: Claims Department
2601 10th Ave. North, Suite 100
Palm Springs, FL 33461-3133

Please **do not** submit duplicate appeals as this will delay the review process.

As a reminder, providers may request Claims or Request for Review Status by completing the appropriate form and faxing to the number listed on the form.

If you have questions regarding this bulletin, please contact your Provider Representative at (561) 659-1002.

Please insert this bulletin into your Provider Handbook. The policies and procedures in this bulletin supersede any related policies and procedures within the handbook.