BAYLOR SCOTT & WHITE HEALTH PLAN
ADJUSTMENT & REDETERMINATION REQUEST COMMUNICATION PROCESS

Below you will find the steps necessary to submit a claim for reprocessing (adjustments or redetermination requests). For Commercial Claims, provider should contact our Claim Review Line to submit a redetermination at 833.542.8179.

PROCESS FLOW:

All Baylor Scott & White Health Plan (BSWHP) claims submitted for redetermination (adjustments & redetermination requests), must be mailed or sent through the Provider Portal (faxed copies of requests are not accepted) to:

Baylor Scott & White Health Plan
ATTN: Provider Claims Redetermination Request
P.O. Box 211342
Eagan, MN 55121-1342

BSWHealthPlan.com/Pages/ProviderPortal.aspx

REDETERMINATION REQUEST REQUIREMENTS

1. Providers or inquiring parties will have only one (1) opportunity to submit a redetermination request on a claim. Multiple requests submitted on a single claim will not be processed and will be returned as "previously reviewed".
2. Providers **must** complete a Provider Claims Redetermination Request Form, failure to do so will result in the request being returned to the requestor for completion.
3. One (1) claim per form should be submitted. Each claim must have its own Redetermination Form.
4. The provider should attach any pertinent supporting documentation (i.e. proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records.
5. Requests for Redeterminations must be submitted within **90 days** from the original determination date. (120 days for Medicare Advantage Claims; 1 year for Out-of-State Providers).

PROVIDER CLAIM REDETERMINATION REQUEST FORM

In order to expedite the processing of your request, this form **MUST** be used. Please complete all of the following information for each redetermination; if not completed, the correspondence will be returned to the provider for correction.

Review Submission Date: _____

Provider Detail

Provider Name: _____

Provider Address: _____

City: _____ State: _____ Zip Code: _____

Billing TIN#: _____ Billing NPI #: _____

Member Detail

Member Name: _____ Member ID #: _____

Claim Detail

Claim #: _____ Date of Service: _____

Choose the Reason for Redetermination that best represents your request:

☐ Authorization obtained (***do not appeal for medical necessity, no retro auth considered***)

☐ Coordination of Benefits/Third Party Resources (**attach primary carrier EOP/EOB**)

☐ Eligibility/Newborn

☐ Medical Necessity/Medical Records (**only if records requested by the Health Plan or denied for correct coding CES**)

☐ Denied "No TPI on File" (Texas Medicaid Only)

☐ Non-Covered (***do not appeal if authorization not obtained, no retro auth considered***)

☐ Overpayment (**request Health Plan to recoup claim**)

☐ Provider Contract/Information Updated

☐ Services Excluded/Not Included in Contract (***do not appeal for medical necessity, no retro auth considered***)

☐ Surprise Billing

☐ Underpayment/Pricing/Reimbursement

☐ Enter Denial Reason Code(s) Found on EOP/835:

_____

Please send this form, your EOP and any supporting documentation (i.e. surgical notes, office visit notes, pathology reports, and/or medical records, primary carrier EOP/EOB) to the address below.

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