**RECONSIDERATION REQUEST**

NEW MEXICO MEDICAID

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| **Only** use this form to submit additional information for a previously **denied** claim for reprocessing.   * Use this form to submit proof of timely filing for repeated untimely filing denials with extenuating circumstances (Note: Do not use the reconsideration form for normal timely filing denials, resubmit claims with proof of timely filing). * This form must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back. * Reconsideration requests cannot be completed via the web portal. * For reconsideration request exceeding 5 claims or more, please contact New Mexico Medicaid Provider Relations at [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us).   **MAIL TO:**  CONDUENT  P.O. BOX 26500  ALBUQUERQUE, NM 87125 | |
| **ALL FIELDS BELOW**  **(SECTIONS A,B,C,D)**  **ARE REQUIRED TO BE COMPLETED IN ORDER TO PROCESS THIS REQUEST**  **INCOMPLETE FORMS WILL BE RETURNED** | |
| **SECTION A: Provider Information** | **SECTION B: Claim Information** |
| **Billing NPI (Must be 10 digits)**    **OR**  **Billing NM Provider ID** | **Client ID#**    **TCN (Must be 17 digits)** |
| **SECTION C: Detailed Reason for Request** | |
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| **SECTION D: Authorization** | |
| **Requestor Name**  By signing below, I hereby certify that I am authorized to make the above request  **Requestor Signature** | **Requestor Email**    **Requestor Phone**    **Date** |