**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.

**MAIL TO:**CONDUENTP.O. BOX 26500ALBUQUERQUE, 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** |