

2025 SHL Provider Summary Guide



Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

- Please submit a separate claim reconsideration request form for each request
- No new claims should be submitted with this form.

Member Information (Required Information)			
Line of Business: (circle one) HPN SHL Medicaid			
Member ID and Date of Birth:	Claim #:	Date of Service:	Billed Amount:
Member Last Name	First Name	MI	Expected amount owed:

Physician/Health Care Professional Information			
Tax Identification Number (TIN):	Physician Name/Facility or other health care professional (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):	Email Address:	Contact Name and Telephone Number:

Reason for request: (please circle applicable reason)

- Exceeds Timely Filing
- Additional Information
- Coordination of Benefits
- Resubmission of a corrected claim
- Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
- Prior Authorization/Referral denial
- Resubmission of "Bundled/Incidental" services
- Carve-Outs
(Explain below)

Please include what you are expecting from HPN/SHL regarding this Claim Reconsideration

Comments:

Required attachments:

- Copy of EOP - Claim Form is **ONLY** required for Corrected Claims Submissions
- Other required attachments as outlined in the Claims Reconsideration Reference Guide