Claims Reconsideration Form

TRICARE West Region

For Provider Use Only

Use this form to request a review of a previously processed claim for which you do not agree with the initial outcome. All reconsideration requests should be submitted within 90 days of the date documented on the provider remit notice. Please include any supporting documentation necessary to assist with your request.

Requester Information

Last Name: _____ First Name: _____

Email Address: _____ Phone (xxx-xxx-xxx): _____

Reason for Reconsideration Request

Please select one of the reconsideration reasons from the list below:

- ☐ Authorization/Penalty Review
- ☐ Recoupment/Offset Review
- ☐ Timely Filing Review
- ☐ Other Health Insurance/Coordination of Benefits Review
- ☐ Pricing/Fee Review
- ☐ Other: _____

Service Information

Date Printed on Provider Remit Notice (MM/DD/YYYY): _____ Claim ID Number: _____

Date of Service Start (MM/DD/YYYY): _____ Date of Service End (MM/DD/YYYY): _____

Provider Information

Rendering Provider Name: _____ Facility/Group Name: _____

National Provider Identifier (NPI): _____ Taxpayer Identification Number (TIN): _____

Beneficiary Information

Last Name: _____ First Name: _____

Beneficiary Date of Birth (MM/DD/YYYY): _____

Sponsor SSN (xxx-xx-xxxx): _____ or DoD Benefits Number (DBN) (xxxxxxxxx-xx): _____

Additional Details

Please describe your concern(s) regarding the outcome of the claim.

Send completed form and supporting documentation via fax to 866-852-1969 or mail to:

TRICARE West Provider Claims Correspondence
P.O. Box 2748
Virginia Beach, VA 23450