

CONTRACTED PROVIDER APPEAL/CORRECTED CLAIM FILING POLICIES

This information pertains to contracted providers only. “Non-Contracted Provider Appeal Rights” is a separate link in the “Educational Tools” section of this website.

To ensure your appeal and/or corrected claim are received in a timely manner, please adhere to the following policies.

- APPEAL** – must be received at HealthSpring within 180 days from the date of the initial HealthSpring Remittance Advice. Be sure to attach medical records/procedure notes, insurance card presented on date of service or other documentation to support your appeal. **NOTE:** Billing system print screens are NOT ACCEPTED for proof of timely filing.
- “SECONDARY CARRIER” APPEAL** – must be received at HealthSpring within 120 days from the date on the Primary Carrier’s EOB. The Primary Carrier’s EOB **MUST BE SUBMITTED** with appeal and initial claim.
- CORRECTED CLAIMS** – must be received at HealthSpring within 180 days from the date on the initial HealthSpring Remittance Advice. These claims must be clearly marked “CORRECTED” in pen or with a stamp directly on the claim form. All lines on the original claim MUST be on the corrected claim to avoid a total recoupment of the initial reimbursement or denial of the corrected claim as a duplicate.
- CLAIM INITIALLY FILED TO INCORRECT CARRIER** – Appeal must be received at HealthSpring within 120 days from the date of the denial on the incorrect carrier’s EOB/RA (as long as the claim was initially filed to that carrier within 120 days of the date of service). The denial **MUST BE SUBMITTED** along with the claim for payment consideration.
- Appeals submitted to HealthSpring after these time limits will not be considered for payment.

IMPORTANT: HealthSpring providers are granted one level of appeal. Therefore, ensure all related appeal documentation is **INCLUDED** with your appeal request.



Provider appeal requests must include:

1. Letter (on letterhead) clearly stating **WHAT** is being appealed and **REASON** for appeal request.
2. Member name, member’s HealthSpring ID number, provider name, date of service, member information, claims numbers, etc.
3. Supporting documentation.
4. Contact information – name, title, mailing address, phone, fax and email address.

MAIL APPEAL TO:

**HealthSpring
ATTN: Solutions Unit
PO Box 24087
Nashville, TN 37202-4087**

FAX (under 25 pages) appeal request to: 615-401-4584/ Attn: Solutions Unit

IF INITIAL CLAIM WAS FILED ELECTRONICALLY:

- In the case of Timely Filing appeals, the EDI Acceptance Report that shows the date the claim was **RECEIVED AND ACCEPTED** by HEALTHSPRING (rather than your clearinghouse) **MUST BE SUBMITTED** with your appeal. **NOTE:** Billing system print screens are **NOT ACCEPTED** for proof of timely filing.
- Attachments to claims will not transmit electronically.