Excellus

REQUEST FOR TIMELY FILING REVIEW

We will consider circumstances beyond a provider's or member's control that resulted in delayed submission of claims on a case-by-case basis. Please use this form to request a review of your or your patient's contractual timely filing limit. **Note:** You must provide supporting documentation with this request.

IMPORTANT: If you, as a participating provider, fail to file claims within your contractual timely filing limit, you cannot bill Excellus BlueCross BlueShield members for covered services associated with those claims unless the claim is for a non-Excellus BCBS BlueCard® member.

Request Date:	**Provider Name:**	**Provider Billing or Tax ID #:**
Subscriber Name:	**Subscriber ID Number:** (include prefix and suffix)	**Subscriber's Date of Birth:**
Member Name	**Member Phone Number and/or E-mail:**	
Claim Number or Charged Amount:	**Date of Service:**	**Procedure Code:**
Provider Office Contact Name	**Provider Office Contact Phone Number and/or E-mail:**	

Requestor:

__ Participating Provider

Claim Information:

___ This claim has never been submitted to Excellus BCBS.

___ This claim has already been submitted to Excellus BCBS at least once.

____"Complete" or "Clean" Claim was submitted to Excellus BCBS within the timely filing limit (attach copy of electronic acceptance report or other **evidence that the claim was billed multiple times on different dates**)

____Claims originally submitted to another carrier (attach copy of other carrier's EOB, EOP or remittance).

____Claims originally billed to the member as "self pay" (attach information that indicates how and when you found out the member had Excellus BCBS insurance)

____Claim was originally paid by another carrier who has retracted its payment due to Excellus BCBS being determined as primary (attach copy of EOB, EOP, remittance or notice of retraction)

____Claim involves subrogation/workers' compensation/no-fault or Medicare exhausted benefits (attach copy of other carrier's EOB, EOP or remittance)

____Medicare is primary for this claim (attach copy of other carrier's EOMB, where applicable)

____Other type of timely filing reconsideration (attach copy of supporting documentation)

Forward completed form and documentation within 120 days of Remittance.

Mail this form and attachment(s) to: PO Box 21146, Eagan, MN 55121