



Curative Claim Appeal & Reconsideration Form

Use this form to request a Claim Reconsideration or, if a Reconsideration has already been completed, a Claim Appeal.
A Reconsideration must be submitted and reviewed before an Appeal will be considered.

Section 1 – Claim Information

Claim Number (Required – one per form): _____

Date(s) of Service: _____

Member ID: _____

Member Name: _____

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

Provider Name: _____

NPI / TIN (Required): _____

Pay-To Address (Attach W-9): _____

City, State ZIP: _____

Section 2 – Submission Type

- Claim Reconsideration** – Administrative or payment-related dispute (e.g., underpayment, COB, timely filing, incorrect denial code, or missing information).
- Claim Appeal** – Submit only after a Reconsideration determination has been issued and you disagree with the outcome (e.g., medical necessity, prior authorization, level of care).

Section 3 – Prior Submission Reference

- Yes** – Related to a prior reconsideration or appeal (**attach determination letter or decision**).
- No** – First submission for this claim.

Section 4 – Reason for Request (choose one)

- Authorization Denial** – Missing/invalid authorization, exceeding auth limits, medical necessity or clinical determination.
- Code Audit / Edit** – Dispute related to system code audit or post-payment review.
- Coordination of Benefits (COB)** – Denied for other insurance or missing COB documentation.
- Duplicate Claim / Line** – Denied as duplicate, or specific claim lines denied as duplicates.
- Filing Limit** – Denied for untimely filing or insufficient proof of timely submission.
- Incorrect Denial Code** – Denied using an incorrect or inconsistent denial code.

Payer Policy: Payment – Claim not paid as expected due to payer policy, bundling/unbundling, modifier/code issue, or global reimbursement.

Request for Additional Information – Denied for missing or incomplete documentation.

Other (explain in Section 5).

Section 5 – Description of Request

Provide a concise explanation of the issue and the requested action:

Section 6 – Supporting Documentation (attach all applicable)

EOP / ERA (Required)

Medical Records

Authorization / Referral

Correspondence / Other

W-9 (Attach)

**Including the current W-9 helps prevent delays in processing provider correspondence. **

Section 7 – Certification

I certify that the information provided on this form and in the supporting documentation is true, accurate, and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Printed Name _____ Title: _____

Contact Email: _____ Phone: _____

Section 8 – Submission Instructions

Preferred Method: Email the completed form and attachments to **Providers@curative.com**

Email Subject Line Format: 'Claim Reconsideration – [Claim Number]' or 'Claim Appeal – [Claim Number]' (Example: Claim Reconsideration – 1234567890)

Do not include PHI (e.g., member name or DOB) in the subject line.

Mail Option (**if email unavailable**): Curative Health Plan – Attn: Provider Appeals, PO Box 1786, Austin, TX 78767

Compliance Notice

⚠ One claim per form submission

Submissions without required attachments or received after 90 days from the EOP/ERA (unless otherwise specified in your contract) may be closed with no action. Curative will issue determination letters through standard provider correspondence channels; the email inbox is for intake only.