curative

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 **ProviderCustomerService@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.