Policy Information			
Policy Title	Provider Reconsideration Request Policy	**Current Version Publish Date**	10/2025
Policy Manual	Reimbursement	**Original Effective Date**	10/2025
Policy Number	11	**Next Review Date**	Annual

Policy Applicability (LOB)			
☒Medicare Inc ☒Medicare WI	☒Commercial IA ☒Commercial WI	☒Commercial IL ☒CPPHP (Kansas)	☒Health Choices

Policy Statement and Purpose

To define the process for providers to submit reconsideration requests for claims decisions.

This policy applies to Provider Reconsideration requests except non contracted providers with adverse benefit determinations for Medicare beneficiaries.

Policy Definitions

Adverse Benefit Determination- a formal decision to deny, reduce or terminate a benefit or payment request.

eLink- a self service portal for MAHP members and providers to view information and submit requests.

eHealthChoices – a self service portal for Health Choices members and providers to view information and submit requests.

Timely Filing - the period specified in the provider contract within which a provider must submit a claim, or reconsideration request to the health plan. Timely filing is typically calculated from the date of service or discharge date except as listed in this policy.

Policy Provisions and Required Procedures

Provider reconsideration requests are accepted only through the provider portal as outlined below:

• eLink (Medical Associates Health Plan Members): https://www.mahealthplans.com/hp/for-businesses/providers/
• eHealthchoices (Health Choices Members): https://healthchoicesplans.com/providers/

Reconsideration requests submitted through any other method will be redirected to the applicable portal. MAHP/HC maintains a database of all provider reconsideration requests for tracking and reporting purposes.

Limitations
Adverse Benefit Determinations are allowed only one (1) reconsideration request. Subsequent requests for the same determination will be upheld without additional review.

Timeliness Requirements
Reconsideration requests must be received within the timely filing limitation stated in the provider's contract and within one (1) year of the date of service.

Exceptions:
• If MAHP/HC is the secondary payer, the timely filing period is calculated from the date of the primary payment.
• Newborn claims are allowed 180 days from the date of birth to accommodate time needed to determine the primary/secondary payer.

Prior Authorization Responsibility
Per the provider contract, it is the responsibility of the provider to obtain all required prior authorizations. The list of services requiring prior authorization is available on the provider pages and through the provider portals. Requests for retroactive authorization will be reviewed in accordance with plan policy and contractual provisions.

Decision Timeframe
Reconsideration request decisions will be communicated in writing within 30 days of receipt.

Related Policies			
Related Training/ Job Aids			
NCQA Standard			
References	Provider Contract Provider Portals (ELink and Ehealthchoices)		
Exhibits			
Policy Owners / Reviewers			
Department Owner	Lisa Kuhls, Provider Relations Manager	**Date Reviewed**	
Department Reviewer	Network Strategy Committee	**Date Reviewed**	
Approving Committee if applicable	☐Compliance ☒UMC ☐QIC ☐Board of Directors ☐Other: _____	**Date Approved**	
History			
Date of revision	*Summary of changes; this policy replaces Membership policy #21* Prior Reviews Revised: Reviewed:		