Independent review provider reconsideration request form

Please return completed form by mail or email to:
Humana Healthy Horizons in Louisiana, Attention: Independent Review
1 Galleria Blvd, Suite 1000, Metairie, LA 70001-2081
Email: **LAIndependentReviewRequest@Humana.com**

From: _____

Phone: _____ **Email:** _____

Required information	
Member name:	Member ID:
Date(s) of service:	Remittance advice date:
Amount billed:	Amount paid:
Claim number:	Pended claim: ☐ Yes ☐ No
Denial reason:	Denial code:
Procedure codes billed:	

To request reconsideration, providers have 180 days from the date a claim denied in whole or partially, or recoupment date of a claim; 60 calendar days if the MCO failed to issue remittance advice.

Please use the space below to provide the reason for dispute and any other necessary information, along with attachments, to enable a thorough reconsideration.

Signature:	Date:

The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with R.S. 46.460.81, within five calendar days after the receipt of the request and render a final decision by providing a response to the provider within 45 calendar days from the date of the receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

Humana Healthy Horizons® in Louisiana

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