



# TPAC Claim Action Request Form

Please complete the following information to request reconsideration of payment:

Request Date: \_\_\_\_\_

**Provider Information**

Requester Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Medical Group Practice Name: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_ NPI: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Remittance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Provider Fax Number: \_\_\_\_\_

Provider's email address: \_\_\_\_\_

**Patient Information**

Patient Identification Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Date of Service: \_\_\_\_\_

**Type of Action Requested**

\_\_\_ Medical Review (records attached): \_\_\_\_\_

\_\_\_ Corrected billing: \_\_\_\_\_

\_\_\_ Duplicate payment: \_\_\_\_\_

\_\_\_ Request for reconsideration (attachment included describing why payment should be reconsidered)

\_\_\_ Timely filing: \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

**Additional Comments**

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