**RECONSIDERATION REQUEST**

NEW MEXICO MEDICAID

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| **Only** use this form to submit additional information for a previously **denied** claim for reprocessing.  For requests **exceeding 5 claims**,  Contact provider support via email at [NMProviderSupport@conduent.com](mailto:NMProviderSupport@conduent.com) for guidance.   * Submit this form with claims that are past the timely filing deadlines. Denied claims that are within the timely filing period should be resubmitted with proof of timely filing. * This form must be submitted with a corrected CMS-1500, UB-04 or Dental claim form with red drop out ink and legal claim notice. Attach any required documents to the claim. * Reconsideration requests cannot be submitted via the web portal.   **MAIL TO:**  CONDUENT  P.O. BOX 26500  ALBUQUERQUE, NM 87125 | |
| **ALL FIELDS BELOW ARE REQUIRED**  **(SECTIONS A,B,C,D)**  **INCOMPLETE FORMS WILL BE RETURNED** | |
| **SECTION A: Provider Information** | **SECTION B: Claim Information** |
| **NPI (Must be 10 digits)**    **OR**  **NM Provider ID** | **Client ID#**    **TCN (Must be 17 digits)** |
| **SECTION C: Detailed Reason for Request** | |
|  | |
| **SECTION D: Authorization** | |
| **Requestor Name**  By signing below, I hereby certify that I am authorized to make the above request  **Requestor Signature** | **Requestor Email**    **Requestor Phone**    **Date** |