**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 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:**CONDUENTP.O. BOX 26500ALBUQUERQUE, 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** |