RECONSIDERATION REQUEST

NEW MEXICO MEDICAID

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:
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)	Client ID#
OR	
NM Provider ID	TCN (Must be 17 digits)

SECTION C: Detailed Reason for Request

SECTION D: Authorization	
Requestor Name	Requestor Email
	Requestor Phone
By signing below, I hereby certify that I am authorized to make the above request	
Requestor Signature	Date