new mexico health connections

Claim Reassessment/Adjustment Request Form

Providers, facilities, and other ancillary care professionals should complete this form to request a claim reassessment.

Do not use this form for formal appeals or grievances—please follow your standard appeals process and use the standard appeals and grievance form required.

Please mail this form and your corrected claims to: New Mexico Health Connections, P.O. Box 3828, Corpus Christi, TX 78463, *OR* fax to: 1-312-548-9943.

PROVIDER/GROUP/FACILITY INFORMATION		
Physician/Group/Facility Name:		
Provider TIN/NPI Number:		
Contact Name:		
Phone Number:	**Fax Number:**	
Email Address:		
Billing Address:		
City:	**State:**	**Zip Code:**

MEMBER INFORMATION	
Member Last Name:	**First Name:**
DOB:	**Member ID Number:**

CLAIM INFORMATION		
☐ **Provider**	☐ **Facility**	☐ **Ancillary Health Care Professional (DME, Lab, etc.)**
Claim Number:	**DOS:**	
Billed Amount:	**Paid Amount:**	

Reason: (Choose one of the adjustment request reasons from the drop-down menu below)

Choose Reconsideration Reason

Reason: