[Date]

[Provider Name]
[Address1],[Address2]
[City], [State] [Zip]

PLEASE INCLUDE THE FOLLOWING RETROSPECTIVE CLAIM ACCURACY (RCA) VOUCHER NUMBER ON YOUR CHECK:
[Reference ID#]

RECONSIDERATION DETERMINATION

Dear Provider,

In an effort to provide an excellent customer experience, Blue Cross Blue Shield of North Dakota (BCBSND) periodically conducts reviews of previously processed claims. BCBSND has partnered with Cotiviti, Inc. to conduct post payment reviews of paid medical claims. Based on the additional information you submitted with your reconsideration request in response to our earlier Overpayment Notice, we have made the following determinations detailed below.

If we do not hear from you concerning these accounts, it will result in automatic recovery of overpayment(s) by BCBSND, as established in your provider agreement.

If you disagree with this request for recovery of overpayment, you may request a second level reconsideration review by sending your written request for an appeal with a copy of this notification letter to BCBSND within **45** calendar days of the date this letter via fax to 701-277-2209 or mail to the following address:

Blue Cross Blue Shield of North Dakota
PO Box 1570
Fargo, ND 58107-1570

A request for reconsideration received by BCBSND after the 45-day time limit has ended will result in a claim denial. Any further opportunity for payment of the claim is waived by the provider for failure to respond timely.

Thank you for your cooperation and prompt attention to this matter.

Sincerely,
HC BCBSND Correspondence Team
Cotiviti, Inc.
203-529-4199

REMITTANCE COUPON - PLEASE RETURN	
Cotiviti, Inc. Attn: Claims Review – HC BCBSND Correspondence Team Hillcrest Building 731 Arbor Way, Suite 150 Blue Bell, PA 19422	**PLEASE INCLUDE THE RCA VOUCHER NUMBER ON YOUR CHECK:** **[Reference ID#]**

Line Num	[Client] Ref #	Patient Name PT A/C Num	Member Number	Date of Service	Procedure Code	DRG	Chk Num Chk Date	Amt Paid Refund Due
[LN]	[Cnly Ref]	[Patient Name] [PT Account Num]	[Member ID]	[StartDOS] To [EndDOS]	[Proc Code]	[DRG]	[Check] [Chkdate]	[Paid Amt] **[Refund Amt]**

Claim Number: [Claim ID] **Plan Name: [Plan Code]**

PROVIDER RENDERING TREATMENT: [Provider Name]

Original Error Explanation: [Claim Error Description]
Date of Original Refund Request: [1st Refund Letter Date]
Date Reconsideration Received: [Received Date]
Date Reviewed: [Review Date]
Reconsideration Outcome: [Outcome]
Reconsideration Notes: [Determination Notes]

AGREEMENT WITH AUDIT FINDINGS: YES / NO

PROVIDER REPRESENTATIVE

_____ _____
Provider Representative Date

_____
Print Name

PREFERRED REPAY METHODOLOGY: AUTHORIZE RECOUP