



[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

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FOR COTIVITI CUSTOMER SERVICE REGARDING OVERPAYMENT ISSUES, PLEASE CALL 203-529-4199

[Letter RCA 2.2]



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

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[Letter RCA 2.2]