Phone: (800) 564-5465
Fax: (860) 975-0841

TIMELY FILING WAIVER REQUEST

REQUIRED INFORMATION FROM PROVIDER	
Date of Request	
Provider Name	
Provider Tax ID Number	
Reason requesting reconsideration of timely filing	
Total Number of Claims	
Total Number of Members	
Beginning Date of Service	
Ending Date of Service	
Reason for not submitting claims timely	
Provider Representative	

Did Provider Representative provide documentation on education of provider?	☐	YES	☐	NO

MERCY CARE RBHA INTERNAL USE		
Date	Item	Reference
	Provider Notification	
	Contract Signed Date	
	Contract Updated in the System Date	
	Number of Claims Previously Paid for Provider*	
	Number of Claims VOIDED for Provider*	
	Total for Provider TIN for Contract Year (10/1 – 9/30	
	Recommendation	

* Note the first submission date / first voided date