



RESUBMISSION

Please complete this form and return one for each claim resubmission.

Please select the appropriate plan:

MCCC MCA Mercy RBHA MCLTC DD

Date of Resubmission:	
Member Name:	
Provider NPI #:	
Provider Tax ID #:	
Original Claim Number:	
Date of Service:	
Resubmission Reason:	

Use the checklist below to help with correct claim processing

<input type="checkbox"/>	Did you remember to use a new claim form?
<input type="checkbox"/>	Did you remember to stamp the top of the claim form as "Resubmission"?
<input type="checkbox"/>	Did you remember to make sure all the information from your original claim form is included on the new claim form, only changing/updating the information that was either missing or incorrect?
<input type="checkbox"/>	Did you remember to include a copy of the Remittance Advice from the original claim that was denied or paid incorrectly?
<input type="checkbox"/>	Did you remember to include any additional required documentation to process the claim (i.e., medical records, etc.)?
<input type="checkbox"/>	Did you remember to include a Share of Cost (SOC) letter from AHCCCS for ALTCS members, if applicable?
<input type="checkbox"/>	Did you remember that this Cover Letter should be the first page of your resubmission paperwork?

Acknowledgement

<input type="checkbox"/>	I acknowledge that this resubmission is NOT a claims dispute or appeal.
--------------------------	---

PLEASE MAIL RESUBMISSION REQUESTS TO:

MERCY CARE CC, LTC, DD, DCS, MERCY CARE ADVANTAGE

MERCY CARE ACC - RBHA

Medical Claims

Attn: Resubmissions
P.O. Box 982975
El Paso, TX 79998-2975

Medical Claims

Attn: Resubmissions
P.O. Box 982976
El Paso TX 79998-2976