

# RECONSIDERATION REQUEST

NEW MEXICO MEDICAID

**Only** use this form to submit additional information for a previously **denied** claim for reprocessing.

- Use this form to submit proof of timely filing for repeated untimely filing denials with extenuating circumstances (Note: Do not use the reconsideration form for normal timely filing denials, resubmit claims with proof of timely filing).
- This form must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back. (one Reconsideration Request Form per claim)
- Reconsideration requests cannot be completed via the web portal.

**MAIL TO:**  
CASA  
P.O. BOX 930  
Bernalillo, NM 87004

**ALL FIELDS BELOW  
(SECTIONS A,B,C,D)  
ARE REQUIRED TO BE COMPLETED IN ORDER TO PROCESS THIS REQUEST**

**INCOMPLETE FORMS WILL BE RETURNED**

<b>SECTION A: Provider Information</b>		<b>SECTION B: Claim Information</b>	
<b>Billing NPI (Must be 10 digits)</b> <input type="text"/>		<b>Client ID#</b> <input type="text"/>	
<b>OR</b> <b>Billing NM Provider ID</b> <input type="text"/>		<b>TCN (Must be 17 digits)</b> <input type="text"/>	
<b>SECTION C: Detailed Reason for Request</b>			
<b>SECTION D: Authorization</b>			
<b>Requestor Name</b> <input type="text"/>		<b>Requestor Email</b> <input type="text"/>	
<b>Requestor Signature</b> <input type="text"/>		<b>Requestor Phone</b> <input type="text"/>	
		<b>Date</b> <input type="text"/>	

By signing below, I hereby certify that I am authorized to make the above request