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.
- Reconsideration requests cannot be completed via the web portal.
- For reconsideration request exceeding 5 claims or more, please contact New Mexico Medicaid Provider Relations at NM.Providers@state.nm.us.

MAIL TO:
CONDUENT
P.O. BOX 26500
ALBUQUERQUE, NM 87125

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

INCOMPLETE FORMS WILL BE RETURNED

SECTION A: Provider Information	SECTION B: Claim Information
Billing NPI (Must be 10 digits)	**Client ID#**
OR **Billing NM Provider ID**	**TCN (Must be 17 digits)**

SECTION C: Detailed Reason for Request

SECTION D: Authorization

Requestor Name

Requestor Email

Requestor Phone

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

Requestor Signature

Date