

CLAIMCHECK RECONSIDERATION FORM

Beneficiary Name: _____

MS Medicaid ID #: _____

TCN #: _____ Paid Date: _____

Date of Service: _____

Claim Check Edit: (Circle Edit Number On Remittance Advice): 3432 3434 3435 3436 3437 3444

Procedure Code (s): _____

Questions/Comments:

Provider Name: _____ Provider #: _____

Provider Address: _____

Provider Contact: _____ Telephone #: _____

- Please Check: Have you completed all of the ClaimCheck Reconsideration Form?
 Have you attached paper copy of claim?
 Have you attached copy of remittance advice?
 Have you attached any additional substantiating information which you wish to have considered upon review?

MAIL TO: ACS
Attn: Medical Review
P. O. Box 23080
Jackson, MS 39225