Request for Claim Review Process via the Provider Portal

1. On the Provider Portal homepage, select **Claims** and then **Check a Claim.**



 Select to view claim by Member ID or Claim Number. Enter the Member ID or Claim Number and select Go.

Claim Status

Please note, until a claim is finalized in Mass General Brigham Health Plan system, the final disposition of the claim is subject to change. For finalized claim detail, please refer to your Mass General Brigham Health Plan Explanation of Payment (EOP). The Provider Portal will only display data for claims on which the currently selected site is the pay to entity.

| or Claim Number: Ente | er 10-digit with hyphen. | |
|--------------------------|--|--------------|
| For Member ID: Enter M | lass General Brigham Health Plan Member ID (exact mate | Claim Number |
| For Current Site: Only c | c Enter full of partial member name (Last, First) of date of laims for the selected Site are shown. | |
| | | |
| | | |
| | | |
| View Claims By: | Claim Number | ~ |
| View Claims By: | Claim Number OR <u>Show All Claims for This Site</u> | |
| View Claims By: | Claim Number OR <u>Show All Claims for This Site</u> | - V |

 Within the appropriate claim, select Submit Claim Review at the bottom of the page.

Claim

| oranni reannoon. | | 231 E | | | Membe | r ID: | R2 | 2 | | |
|-----------------------------|------------|---|-------------------------|----------|----------|-------------|------------------|----------|----------|----------|
| Member Name: | | | | | Membe | r Date Of B | irth: | / /1 | | |
| Status: | | PAID | | | Submis | sion Date: | 10 | /28/2024 | Ļ | |
| Servicing Provid | ler: | | | | Servicin | g Provider | NPI: | | ÷ | |
| Total Charges: | | \$385.00 | | | Paid An | nount: | | | | |
| Check Date: | | Che | | | Check N | lumber: | | | | |
| Eop Link: | | Download Corresponding Explanation of Payment | | | | | | | | |
| Date Of Service | Start: | 07/24/2023 Date Of SErvice End:: | | | d:: 07 | /24/2023 | } | | | |
| Patient Control Number: | | | | | | | | | | |
| Primary Diagno | sis: | 110 - ESSENTIAL F | PRIMARY HY | PERTENSI | NC | | | | | |
| Secondary Diagnosis(es): | | | | | | | | | | |
| Claim Message | S: | | | | | oor ongrom | ij onango | | | |
| im Services | | | | | | | | | | |
| e Status Rev CPT Mo | lifier | Description | Units Billed | Allowed | COB | Deductible | Co- Insruance | Сорау | Withheld | Paid |
| | OFFICE/OUT | TPATIENT ESTABLISHED LOW | [/] 1 \$395.00 | \$171.45 | \$0.00 | \$0.00 | \$0.00 | \$60.00 | \$11.15 | \$111.45 |

4. Enter all required information in the **Request** for Claim Review Form.

Important notes:

- A claim review form must be completed and attached to this request. Please add any other supporting documentation for review to the claim review form and upload as one document.
- If previous correspondence has been submitted to Mass Geneneral Brigham Health Plan, we ask that you not resubmit via the Correspondence Portal.
- Please indicate if this is a duplicate submission and the reason why.

Request for Claim Review Form

COMPLETE ALL INFORMATION REQUIRED ON THE "REQUEST FOR CLAIM REVIEW FORM".

INCOMPLETE SUBMISSIONS WILL NOT BE PROCESSED.

| Please direct any questio | ns regarding this form | to the lan to which you | submit your request for claim review. |
|----------------------------------|------------------------|-------------------------|---------------------------------------|
| Download a claim review | form here. | | |
| | | | |
| This is a duplicate s | submission. | | |
| Reason for second submission: | | | |
| Provider Information | | | |
| Provider Name: | | | : |
| Contact Name: | Brandon Veazie |]• | |
| NPI: | |] | |
| Contact Phone: | |]• | |
| Contact Fax: | |]• | |
| Contact Email: | | | • |
| Contact Address Information | | | |
| Address: | | | • |
| City: | | | • |
| State: | • | | |
| Zip: | • | | |

- 5. Select appropriate **Review Type** from the dropdown menu.
- Next to Upload Document, select Choose Files to attach the claim review form. Please add any other supporting documentation for review to the claim review form and upload as one document.
- Select Submit. Once your request has been submitted you will receive a Transaction ID for your records.

| Member/Claim Inform | nation |
|---------------------|---|
| Member ID: | R225 |
| Member Name: | |
| Date of Service: | 7/24/2023 |
| Claim Number: | 23 E |
| Denial Code: | • |
| Review Type | |
| Review Type: Contra | act term(s): The provider believes the previously proce 🗸 🔸 |
| Comments: | |
| | |
| | 1 |
| Upload | Document Choose Files No file chosen |
| | Submit |

8. Track your Submissions in the Provider Portal.

| Claim Submitted Reviews | | | | | |
|-------------------------|-----------|-------------|--|--|--|
| Claim Number | Member Id | Member Name | | | |