Cotiviti
<<<Address Line 1>>>
<<<Address Line 2>>>
<<<City, State Zip>>>

<<<Date>>>

CCV - Reconsideration Response – New Determination

<<<Provider Name>>>
<<<Provider Address 1>>>
<<<Provider Address 2>>>
<<<City, State Zip>>>

Dear <<<Provider Name>>>:

Thank you for your letter requesting reconsideration of our audit determination for the following claim:

Patient Account #:	XXXXXXXXXXXXXXXXX	**Subscriber ID:**	XXXXXXXXXXXXX
Facility:	XXXXXXXXXXXXXXXXX	**Dependent ID:**	XXXXXXXXXX
Tax ID:	99-99999999	**Patient Name:**	<<< Last Name, First Name >>>
Provider ID:	999999	**Patient DOB:**	99/99/9999
Payer Name:	<<< Payer >>>	**Patient Gender:**	X
Payer Claim #:	XXXXXXXXXXXXXXXXX	**Date of Admission:**	99/99/9999
Cotiviti ID #:	999999999999	**Date of Discharge:**	99/99/9999
Recon Received:	99/99/9999	**Recon Review Date:**	99/99/9999
Claim Paid Amount $:	99999999.99	**Adjusted Claim Paid Amount $:**	99999999.99

This case, along with any additional documentation submitted, has been carefully reviewed. Based on the information provided, our decision has changed. The new reconsideration determination is shown on page two.

If you have any questions regarding this reconsideration response, please contact Cotiviti Provider Services at <<< (XXX) XXX-XXXX >>>, Monday – Friday from 7:00 AM to 4:00 PM CST/CDT. Thank you for your cooperation with this claim review.

Sincerely,

Cotiviti

<<<Date>>>

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Patient Account #:	XXXXXXXXXXXXXXXXX	**Subscriber ID:**	XXXXXXXXXXXXX
Facility:	XXXXXXXXXXXXXXXXX	**Dependent ID:**	XXXXXXXXXX
Tax ID:	99-99999999	**Patient Name:**	<<< Last Name, First Name >>>
Provider ID:	999999	**Patient DOB:**	99/99/9999
Payer Name:	<<< Payer >>>	**Patient Gender:**	X
Payer Claim #:	XXXXXXXXXXXXXXXXX	**Date of Admission:**	99/99/9999
Cotiviti ID #:	999999999999	**Date of Discharge:**	99/99/9999
Recon Received:	99/99/9999	**Recon Review Date:**	99/99/9999

Reconsideration Determination: <<<New determination – see explanation and post appeal review>>>

Explanation: <<<Insert reconsideration description here>>>

Submitted on Claim			**Post Recon Result**		
Allowed DRG:	170		**Allowed DRG:**	170	
Discharge Disposition:	03		**Discharge Disposition:**	03	
Severity:	XX		**Severity:**	XX	
Birth Weight:	999999		**Birth Weight:**	999999	
Diagnostic Codes:	**ICD Indicator:**	**POA:**	**Diagnostic Codes:**	**ICD Indicator:**	**POA:**
Primary Diag	10	Y	Primary Diag	10	Y
Diag 2	10	Y	Diag 2	10	Y
.			.		
.			.		
.			.		
Diag 25	10	Y	Diag 25	10	Y
Procedure Codes:	**ICD Indicator:**		**Procedure Codes:**	**ICD Indicator:**	
Primary Procedure	10		Primary Procedure	10	
Proc 2	10		Proc 2	10	
.			.		
.			.		
.			.		
Proc 25	10		Proc 25	10	

<<<Date>>>

CCV - Reconsideration Response – New Determination

Patient Account #:	XXXXXXXXXXXXXXXXX	**Subscriber ID:**	XXXXXXXXXXXXX
Facility:	XXXXXXXXXXXXXXXXX	**Dependent ID:**	XXXXXXXXXX
Tax ID:	99-99999999	**Patient Name:**	<<< Last Name, First Name >>>
Provider ID:	999999	**Patient DOB:**	99/99/9999
Payer Name:	<<< Payer >>>	**Patient Gender:**	X
Payer Claim #:	XXXXXXXXXXXXXXXXX	**Date of Admission:**	99/99/9999
Cotiviti ID #:	999999999999	**Date of Discharge:**	99/99/9999
Recon Received:	99/99/9999	**Recon Review Date:**	99/99/9999

Agreement with Determination

If you agree with this decision, please sign and return this letter and Reconsideration Response within 60 calendar days of this letter date to: <<< Cotiviti >>>, <<< Address Line 1 >>>, Address Line 2 >>>, <<< City, State Zip >>>. If no response is received within this timeframe, the claim will be adjusted to reflect this audit determination. Any further opportunity for payment or dispute of payment of the claim is waived by the provider for failure to respond timely.

Printed Name	**Signature of Representative**	**Title**	**Date**

Disagreement with Determination

If you disagree with this decision, you have a right to request a second reconsideration of the determination. Please mail your written request, and additional supporting documentation, within 60 calendar days of this letter date to BCBSND at the second reconsideration address below. **Note: Reconsideration instructions enclosed.**

IMPORTANT INFORMATION ABOUT YOUR RECONSIDERATION RIGHTS

Cotiviti conducts audits on behalf of Blue Cross Blue Shield of North Dakota (BCBSND) in accordance with current industry standards and practices. The mission of the Cotiviti clinical and coding auditor team is to provide complete and accurate results with fair perspective.

Second Reconsideration

If you receive an unfavorable decision on the first reconsideration, you may file a request for second reconsideration. To exercise this right, file your written request, along with any new supporting documentation to support reimbursement of the claim as originally billed, within 60 calendar days of this letter date. All requests for second review must be in writing and sent to:

Blue Cross Blue Shield of North Dakota
PO Box 1570
Fargo, ND 58107-1570
FaxL 701-277-2209

BCBSND will issue a decision within 60 calendar days of this letter date. In order to ensure that the second review receives a fair and impartial review, the second review will be made by clinicians and/or specialists who did not conduct the original audit of the claim.

The second reconsideration is the final determination; no further review or reconsideration will be accepted by Cotiviti or BCBSND.