INSTIL® HEALTH

South Carolina InStil Health Provider Reconsideration Form

This form is intended for use by physicians and other health care professionals in South Carolina. To request a claim review, please complete this form for InStil Health members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

You may wish to seek reconsideration of a claim:

- If you have additional documentation that supports a reversal of the claim determination.
- If you want a reconsideration of the claim adjudication.

Provider Information

Provider's Name: _____ NPI or Tax ID: _____

Phone Number: _____ Ext: _____ Fax Number: _____

Contact Person: _____ Email: _____

Authorized Signature: _____ Date: _____

Patient and Claim Information

Patient's Name: _____ Member ID: _____ Date of Birth: _____

Claim Number *(Do **not** attach claim)*: _____ Date of Service: _____

Reconsideration

Check the appropriate boxes below to specify the type of service and request.

☐ Medical Services
☐ Laboratory Services
☐ Initial Request
☐ Subsequent Request*

Note: Subsequent requests **must include the initial decision along with new or additional information to be re-reviewed.*

Brief description of request/desired action you want us to take as result of this claim review:

_____
_____
_____
_____

Description of attachments included (office records, lab reports, physician orders, etc.):

_____
_____

Please Fax or Mail to (send to only one):

Plan	Reconsideration Time Limit	Fax Number	Mailing Address
InStil HealthPlan	180 days from remit date	803-264-4172	P.O. Box 100324, Columbia, SC 29202-3324