RESUBMISSION

Please complete this form and return one for each claim resubmission.	
Please select the appropriate plan: MCCC ☐ MCA ☐ Mercy RBHA ☐ MCLTC ☐ DD ☐	
Date of Resubmission:	
Member Name:	
Provider NPI #:	
Provider Tax ID #:	
Original Claim Number:	
Date of Service:	
Resubmission Reason:	

Use the checklist below to help with correct claim processing
☐ Did you remember to use a new claim form?
☐ Did you remember to stamp the top of the claim form as "Resubmission"?
☐ Did you remember to make sure all of the information from your original claim form is included on the new claim form, only changing/updating the information that was either missing or incorrect?
☐ Did you remember to include a copy of the Remittance Advice from the original claim that was denied or paid incorrectly?
☐ Did you remember to include any additional required documentation to process the claim (i.e. medical records, etc.)?
☐ Did you remember to include a Share of Cost (SOC) letter from AHCCCS for ALTCS members, if applicable?
☐ Did you remember that this Cover Letter should be the first page of your resubmission paperwork?
Acknowledgement
☐ I acknowledge that this resubmission is NOT a claims dispute or appeal.

PLEASE MAIL ALL RESUBMISSION REQUESTS TO:

MERCY CARE COMPLETE CARE
MERCY CARE ADVANTAGE
Medical Claims
Attn: Resubmissions
P.O. Box 52089
Phoenix, AZ 85072-2089

MERCY CARE RBHA
Medical Claims
Attn: Resubmissions
P.O. Box 64835
Phoenix, AZ 85082-4835

MERCY CARE PLAN
Dental Claims
Attn: Resubmissions
P.O. Box 61235
Phoenix, AZ
85082-1235

AETNA MEDICAID ADMINISTRATORS, LLC
FAMILY PLANNING
Family Planning Claims
Attn: Resubmissions
P.O. Box 60785
Phoenix, AZ 85082-0785