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