OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
PROVIDER NETWORK MANAGEMENT SECTION
MEDICAL CLAIM REVIEW REQUEST FORM

INSTRUCTIONS TO COMPLETE THIS FORM ARE ON THE REVERSE SIDE.

1. PROVIDER INFORMATION

Provider Name________________________________
Address____________________________________
City_______________________________________
State____________________Zip_____________
Contact Person ____________________________

2. SUBMISSION DATE OF THIS FORM

___/___/___

Individual Provider#__ __ __ __ __ __ __

Group Provider#__ __ __ __ __ __ __(*When appropriate*)

Telephone # (______)-____________________________

3. CLAIM INQUIRY INFORMATION

Recipient Name____________________________

Billing #(12digits) __ __ __ __ __ __ __ __ __ __ __ __

Service Date______________________________

or

Discharge Date____________________________

4. CLAIM HISTORY INFORMATION

Transaction Control Numbers

TCN____

TCN____

TCN____

Please note: All transaction control #s are 17 digits

5. Please enter all applicable Medicaid E.O.B. denial codes, which apply to the attached claim. EOB _____ EOB_____ EOB_____ EOB_____

(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs).

6.Explanation of request:________________________________
____
____
____
____
____
____

Internal Use Only

Date of Receipt Stamp

ODJFS USE ONLY

Reviewer ID____________

9 Claim not approved for processing, please see the attached letter.
____
____
____

Each claim requires a separate JFS 06653 Medical Claim Review Request Form
Please call our Interactive Voice Response Unit (IVR) at 1-800-686-1516 for claim status verification.

JFS 06653 (Rev.07/2003)

Instructions for completing this form: This form is not to be used for routine claim submission and/or to request an adjustment to a paid claim. Complete the JFS 06653 Medical Claim Review Request Form (Sections 1, 2, 3, 4, 5, AND 6) when submitting an unpaid claim with a service date of more than one year due to one of the following reasons:

- A delay due to an administrative hearing decision by the Department of Job and Family Services
- A delay in eligibility determination by a county department of job and family services
- Coordination of benefits with Medicare and/or a third party payer

A claim form must be attached to the JFS 06653 Medical Claim Review Request Form, for review and processing purposes. Please include information to document your previous claim submission or the event which delayed your claim submission such as a county letter demonstrating a delay in eligibility and/or a third party payer or Medicare explanation of benefits.

A written response to the JFS 06653 Medical Claim Review Request Form will not be provided when the claim is approved and forwarded for processing. A written response to the JFS 06653 Medical Review Request Form will be provided for those claims which are returned to the provider as not approved for processing.

Please mail the completed JFS 06653 Medical Claim Review Request Form to: ODJFS Provider Network Management Section, P.O. Box 1461, Columbus, Ohio, 43216-1461. For your convenience the JFS 06653 Medical Claim Review Request Form can be downloaded from our web site at **www.state.oh.us/scripts/odjfs/forms** or ordered from the Document Development Section, Warehouse Services Unit at 2098 Integrity Drive North, Columbus, Ohio 43209.

1. Provider Information: Enter the provider's name, street address, city, state, and zip code and contact person.

2. Submission date to ODJFS: Enter the date, the 06653 Medical Claim Review Request Form is being submitted to the department. Enter the numerical seven digit Ohio Medicaid individual provider number, and the numerical seven digit Ohio Medicaid group provider number, when appropriate, and phone number including the area code.

3. Claim Inquiry Information: Enter the recipient name, the 12 digit billing number, and the service or discharge date.

4. Claims History Information: Enter **each** of the 17 digit transaction control number(s) (TCN) along with the remittance advice for the claim review requested. Timely filing and timely resubmission of your claim will assist the department with the review of your claim.

5. EOB Code Information: Enter the Explanation of Benefits (EOB) codes from the department's remittance advice that pertain to the claim.

6. Explanation of Request: Enter an explanation why you are requesting a review of this claim.

IMPORTANT INFORMATION !

Briefly this rule states: *Your initial claim submission must comply with Ohio Administrative Code, Rule 5101:3-1-19.3.* Initial claims must be received by the department within three-hundred-sixty-five days of the date the service was provided, or from the date of discharge. The date of ***receipt*** for purposes of this rule is the date the department receives a claim and assigns a transaction control number. Initial claims received beyond the three-hundred-sixty-five day time limit should not be processed for payment by the department unless the claim submittal is delayed due to the pendency of either an administrative hearing decision by the department or an eligibility determination by a county department of job and family services, or coordination of benefits with a third party payer or Medicare explanation of benefits. Consideration of payment will be made if the claim is received within one-hundred-eighty days of the date of the administrative decision by the department, eligibility determination by the county department of job and family services, or coordination of benefits with a third party payer or Medicare explanation of benefits.