Culinary Health Fund
Administrative Services, LLC

*1901 Las Vegas Blvd. So.*
*Suite 101*
*Las Vegas, Nevada 89104-1309*
*(702) 892-7313*
*www.culinaryhealthfund.org*

October 8, 2021

Re: Update to Provider Reconsiderations and Additional Information for Claims

Dear Valued Culinary Provider:

To further enhance our new claims system and to prevent duplicate and/or missing documents, we are revising our process for the receipt of records. This enhancement will streamline the handling of the documents and records your office submits for Provider Reconsiderations and requests for additional information.

All incoming Provider Reconsideration requests and additional records submitted for claims processing – for example: accident/injury forms, medical records, primary EOB's, et cetera – will be sent to the same location. It is imperative that one of the attached forms is included as the cover sheet, whether you are requesting a Provider Reconsideration or if you are submitting additional records. This will ensure your request is linked to the correct claim.

**Effective immediately** please submit all Provider Reconsideration requests and additional information for claims to the following address using one of the attached forms:

**Culinary Health Fund**
**P.O. Box 211471**
**Eagan, MN 55121**

If you have any questions, please contact provider services at (702) 892-7313, option 2.

Sincerely,

The Culinary Health Fund Administrative Services, LLC

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# ADDITIONAL INFORMATION SUBMISSION FORM

**DATE:** _____

**CLAIM #:** _____

**MEMBER ID#:** _____

**PATIENT NAME:** _____

**DATE OF SERVICE:** _____

**PROVIDER TIN:** _____

**PROVIDER NAME:** _____

**CONTACT PERSON:** _____

**PHONE NUMBER:** _____

**ATTACHMENTS:** Check all that apply

☐ Copy of Claim ☐ Operative Report ☐ Medical Records
☐ Primary Insurance EOB ☐ Itemization

☐ Other _____

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**Eagan, MN 55121**

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# CULINARY PROVIDER RECONSIDERATIONS FORM

**DATE:** _____

**CLAIM #:** _____

**PATIENT NAME:** _____

**DATE OF SERVICE:** _____

**CPT/HCPCS CODE(S) REQUIRING REVIEW:** _____

_____

**PROVIDER TIN:** _____

**PROVIDER NAME:** _____

**CONTACT PERSON:** _____

**PHONE NUMBER:** _____

**REASON FOR REQUEST** (brief description of the issue[s])**:**

_____

_____

_____

_____

_____

**ATTACHMENTS:** Check all that apply

☐ Copy of Claim ☐ Operative Report ☐ Medical Records
☐ CCI guidelines ☐ Contract Language

☐ Other _____

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