Ohio Department of Medicaid

INSTRUCTIONS FOR COMPLETING ODM 06653, MEDICAL CLAIM REVIEW REQUEST

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 ODM 06653 Medical Claim Review Request Form (Sections 1, 2, 3, 4, AND 5) when submitting an unpaid claim with a service date of more than one year due to one of the following reasons:

- Claims submitted past timely filing requirements for wraparound payment for a federally qualified health center (FQHC) or rural health center (RHC)
- Claims submitted past timely filing requirements due to a delay in eligibility determination or a state hearing decision
- Claims submitted past timely filing requirements due to a reversal of payment by a third-party payer
- Claims delayed in submission to, or adjudicated by ODM, due to an action or decision by ODM
- When directed by ODM staff

The ODM 06653 Medical Claim Review Request Form, must be uploaded to the claim during submission 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.

For your convenience the ODM 06653 Medical Claim Review Request Form can be downloaded from our web site at https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM06653fillx.pdf

1. **Provider Information:** Enter the provider's name, street address, city, state, and zip code and contact person, and phone number including the area code.
2. **Submission date to Medicaid:** 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, or NPI when appropriate.
3. **Claim Inquiry Information:** Enter the recipient's name, the 12-digit billing number, and the service or discharge date.
4. **Claims History Information:** Enter **each** of the 13-digit transaction control number(s) (ICN or Claim ID) 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. **Explanation of Request:** Enter an explanation why you are requesting a review of this claim.

IMPORTANT INFORMATION!

Claim submission must comply with Ohio Administrative Code, Claim Submission Rule 5160-1-19.
https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-19