Medical Records Request Form (Commercial/Medicare Advantage)

INSTRUCTIONS:

- This form is required when submitting medical records requested by ConnectiCare.
- This form should **not** be used for appeals.
- Be sure to use a separate form for each request.
- If you are sending more than 100 pages, please use a compact disc (CD), if available, for your submission.
- Send completed form to:

ConnectiCare
Attn: Payment Integrity
175 Scott Swamp Road
Farmington, CT 06034-0546
Fax: 1-212-510-4903

Date requested: _____
Claim number: _____
Date(s) of service (to – from): _____
Member name: _____
Member ID: _____

NDC#, CPT or HCPC, if available: _____
Provider name: _____
Contact name: _____
Contact phone: _____

Did you receive any medical record request for the claim noted above?

Please select "yes" or "no" below.

◯ Yes

If known, please select the reason for the medical records/itemized bill request:

☐ Payment integrity review
☐ Claim denial (indicate denial code below)
☐ Specialized Investigations Unit
☐ Coding review

Other: (Please explain and be as specific as possible.)

◯ No: (Please explain reason for submission.)

If you have any questions, please call Provider Services at 1-800-828-3407.