State of Illinois
Department of Healthcare and Family Services

PAYMENT REVIEW REQUEST FORM (LTC)

FACILITY NAME: _____ FACILITY ID NUMBER: _____

FACILITY REPRESENTATIVE SIGNATURE: _____ DATE: _____

PREVIOUSLY SUBMITTED		1. RECIPIENT NAME	2. RECIPIENT ID NUMBER	3 SERVICE PERIOD MO/YR	4. ALLEGED BALANCE DUE	5. EXPLANATION FOR DISCREPANCY (VERIFICATION DOCUMENT(S) MUST BE ATTACHED FOR THE CORRECTION PROCESS)	AGENCY USE ONLY			
YES	NO						6. PAYMENT AMOUNT RECEIVED	7. PAYMENT AMOUNT RECOUPED	8. PAYMENT VOUCHER NUMBER	9. COMMENTS
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INSTRUCTIONS FOR COMPLETION

All fields must be completed or the form may be returned. All shaded areas are for Agency use only.
To be completed by the facility requesting a review of non-payments, underpayments or overpayments.

Facility Name
Facility ID Number: Enter the facility's Federal Employer's Identification Number (nine digits), plus the last three digits assigned by the Department for billing purposes.

Previously Submitted: Place a check mark indicating whether the information on this form has been submitted before.

1. Recipient name as listed on the MediPlan Card
2. Recipient ID Number as listed on the MediPlan Card
3. Service period (month & year). Indicate the service periods for which the nonpayment, overpayment or underpayment occurred.
4. Alleged Amount Due. Indicate the amount the facility alleges is owed to the facility or to the Department.
5. Explanation for the Discrepancy. This box should indicate the reason for the overpayment or underpayment, such as incorrect level of care, incorrect patient credit, incorrect discharge date, or no bed reserve stay information, etc.
   NOTE: Documentation must be attached to this form to verify of the information to be corrected or changed.

To be completed by the Bureau of Long Term Care.

6. Payment Amount Received. This box will reflect the amount that the Department shows as being paid to the facility for the service period.
7. Payment Amount Recouped. This box will reflect any recoupment made by the Department for the service period via an adjustment.
8. Payment Voucher Number. This box will reflect the voucher number on which the payment was issued.
9. Comments. This box will indicate the current payment status after the department's review. If applicable, it will provide instructions to the facility regarding additional required action that must be taken by the facility to obtain the amount claimed to be due the facility or department.

NOTE: TIME LIMIT FOR BILL SUBMITTAL

To be eligible for payment consideration, a provider claim, bill, nonpayment or underpayment review or adjustment must be received by the Department no later than 12 months from the date on which medical goods or services are provided. This time limit is applicable to both initial and previously rejected claims.

Claims which are not submitted and received in compliance with the foregoing requirement will not be eligible for payment under the Department's Medical Assistance Program, and the State shall have no liability for payment thereof. Time limits are referenced in the following policy and rules.

Medical Assistance Program Handbook
Chapter 100, Topic 141. 2
89 Ill Adm. Code 140. 20 and 140. 25

The completed form should be submitted to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Long Term Care
Internal Operations Section
Payment Review and Adjustment Unit
201 South Grand Avenue East
Bloom Building, 3rd Floor
Springfield, Illinois 62763-0001

Print Form