Good Samaritan
Direct Health

Commercial Plans
Code Edit Review Form

For most commercial providers and networks, Good Samaritan Direct Health uses Change Healthcare's ClaimsXten™ claim editing software to apply code editing rules to medical claims. The rule editing logic considers AMA/CPT coding guidelines, national specialty and academy guidelines, the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) coding guidelines, and input from Change Healthcare's medical review board. Data files supporting these rules are updated at least quarterly, consistent with CMS data releases.

Use this form to request review of claim code edits that cannot be addressed through submission of a corrected claim with appropriate modifier(s). See coding fact sheets at www.gshvindirect.org/Providers for information on ClaimsXten™ edits.

Code edit review is the first step in the formal appeal process. **Do not submit medical records with this request.** Good Samaritan Direct Health may request records for clinical evaluation if the code review moves to formal appeal.

Section I – Instructions

1. Review the coding fact sheet applicable to your denied/adjusted code (found at www.gshvindirect.org/Providers).
2. Review the medical record to determine if a modifier(s) is appropriate for the denied/adjusted code.
   - If YES: Submit a corrected claim with modifier(s) to Good Samaritan Direct Health.
   - If NO: Complete each section of this form and submit it to Member.Services@gshvindirect.org. Good Samaritan Direct Health will respond with code review results no later than 30 days after the date submitted.

Section II – Submitter / Provider Information

Submitter Last Name:	Provider NPI:
Submitter First Name:	Provider Name:
Submitter E-mail:	DATE SUBMITTED:

Section III – Good Samaritan Direct Health Claim Information

Member Last Name:	Claim Number:
Member First Name:	Claim DOS:
Member ID Number:	Claim Billed Amount:

Section IV – Reason for Review

Denied Code:
Denial Reason (see EOP/EOB):
Based on current coding guidelines and your review of member medical records, state specifically why you believe the denial is inappropriate and should be reconsidered.