

Provider Inquiry & Review Process Guide

Update September 2026

Review Type	Description	Preferred Process
Provider Claim Request for Reconsideration	A request for reconsideration is the initial step in seeking review of a claim adjudication. All reconsideration requests must be submitted within sixty (60) calendar days from the date of the explanation of payment (EOP). CountyCare will review and issue a determination within thirty (30) calendar days of receipt of the request.	Submission Instructions Please submit reconsideration requests through the Availity provider portal by following these steps: From the Availity home screen, select Claims & Payments and then click Claim Status. 1. Locate the claim for which you are requesting reconsideration. 2. Select Message this Payer at the top of the screen and complete the required fields. Note: The unique identifier for each submission is the Conversation ID. This can be accessed immediately after submission via the Messaging Queue on the confirmation page ("Your message was successfully sent"). Reviewing Submitted Requests 1. From the Availity home screen, select Messaging on the right-hand side. 2. Search for previously submitted reconsideration requests using available filters (e.g., claim number, conversation ID, member ID). 3. To review older submissions, select Filter and adjust the Date Range as needed. Note: The purpose of this process is to ensure that each claim is submitted individually. If you need to review a large volume of claims, please contact your assigned provider relations representative or contact Provider Services at CountyCareProviderServices@cookcountyhhs.org
	Examples of Reconsideration Requests	
	Fee Schedule Update Reprocessing A reprocessing initiative was completed due to a fee schedule update. Verification through the claims and configuration tracker confirms that all applicable claims were reprocessed. A request is submitted to investigate why a specific claim was not included in the reprocessing effort.	
	Out-of-Network Denial (OS2) A claim was initially denied as out-of-network (remark code OS2). A roster update was subsequently submitted to the Cook County Health (CCH) Provider Data Management team and has been completed. The date of service falls after the provider's effective in-network date. A request is submitted to reprocess the claim, as the provider is now reflected as in-network.	
	Third-Party Liability (TPL) Denial (EO) A claim was originally denied due to third-party liability, as an EOP from the primary insurer was not received (remark code EO). The EOP is now being submitted to allow for coordination of benefits and appropriate claim reprocessing. Note: To submit a medical necessity review, please refer to the Provider Service Authorization Dispute section.	

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Provider Claim Dispute	A provider claim dispute is a formal request for review of a claim determination when a provider disagrees with the outcome of the adjudication. All provider claim disputes must be submitted within sixty (60) calendar days from the date of the explanation of payment (EOP). CountyCare will review and issue a determination within thirty (30) calendar days of receipt of the dispute. Note: To initiate an HFS Complaint through the HFS Portal, a provider claim dispute number obtained through this process is required. Examples of Provider Claim Disputes Third-Party Liability (TPL) Denial (EO) A claim was denied due to third-party liability, as an EOP from the primary insurer was not submitted (remark code EO). The provider disputes this determination, indicating that CountyCare is the primary payer and that no other primary insurance coverage exists. Disagreement with Adjudication Methodology Based on the IAMHP billing manual, the provider disagrees with how the claim was adjudicated and submits a dispute requesting further review and reconsideration of the applied billing guidelines.	Submission Instructions Please submit disputes through the JIRA dispute portal, accessed via the Identifi platform within the Availity provider portal, by following these steps: 1. From the Availity home screen, select Payer Spaces and choose CountyCare Health Plan. 2. Click Identifi SSO and select the appropriate Organization and Provider. 3. Within Identifi, click the account icon (upper right) and select Contact Support to access the JIRA dispute portal. 4. Select Evolent Service Desk, choose CountyCare Provider Disputes and complete the required fields. Reviewing Submitted Requests Please follow steps 1 through 3 above to access JIRA. Within JIRA, click the account icon (upper right) and select Requests to view and track submitted disputes.

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Provider Service Authorization Dispute	A provider service authorization dispute is a formal request for review of a prior authorization determination. Disputes must be submitted within sixty (60) calendar days of the explanation of payment (EOP), and CountyCare will issue a determination within thirty (30) calendar days of receipt. Note: If prior authorization was not obtained before services were rendered, the dispute must include an explanation of the extenuating circumstances that prevented authorization. Requests without sufficient justification may be administratively closed. Examples of Provider Service Authorization Disputes No Authorization Denial (S2) A claim was denied for lack of authorization (remark code S2). Based on the information in the prior authorization look-up tool available on the CountyCare website, the provider believes prior authorization was not required and is requesting review. Medical Necessity Denial Upheld A prior authorization request, including a peer-to-peer review, was denied due to lack of medical necessity. The provider disputes the determination and submits additional medical records supporting medical necessity. Incorrect Member Identification at Time of Service A member presented an incorrect ID card at the time of service. After confirming the member's eligibility with CountyCare, the provider is submitting clinical documentation to support a medical necessity review for a claim denied for no authorization (remark code S2).	Submission Instructions Please submit disputes through the JIRA dispute portal, accessible via the Identifi platform within the Availity provider portal, by following these steps: 1. From the Availity home screen, select Payer Spaces and choose CountyCare Health Plan. 2. Click Identifi SSO and select the appropriate Organization and Provider. 3. Within Identifi, click the account icon (upper right) and select Contact Support to access the JIRA dispute portal. 4. Select Evolent Service Desk, choose CountyCare Provider Disputes and complete all required fields. Note: If no authorization attempt was made prior to services being rendered, providers must include a detailed explanation of the extenuating circumstance in the Description field. Reviewing Submitted Requests Please follow steps 1 through 3 above to access JIRA. Within JIRA, click the account icon (upper right) and select Requests to view and track submitted disputes.

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Authorization Appeal	An appeal is a member right that allows a provider to request review of an adverse benefit determination on behalf of a member. Appeals must be submitted within sixty (60) calendar days from the date of the adverse benefit determination. CountyCare will issue a decision for standard appeals within fifteen (15) business days of receipt. CountyCare may extend this timeframe by up to fourteen (14) calendar days when necessary and will make reasonable efforts to provide the member with prompt oral notification of any delay. For expedited appeals, CountyCare will notify the member and provider of the decision within twenty-four (24) hours of receiving all required information, not to exceed seventy-two (72) hours from receipt of the initial expedited appeal request. Important Requirement: A completed authorized representative form must be submitted with all appeal requests to document that the provider is authorized to act on behalf of the member. The form can be found on the CountyCare website.	Submission Instructions Please submit appeal requests through the Identifi platform within the Availity provider portal by following these steps: 1. From the Availity home screen, select Payer Spaces and choose CountyCare Health Plan. 2. Click Identifi SSO and select the appropriate Organization and Provider. 3. Locate and open the authorization you wish to appeal. 4. Within the authorization, select Actions and click Add Appeal Request. Complete all required fields. Reviewing Submitted Appeals Within Identifi, select Appeals from the upper navigation ribbon to view and track submitted requests.

Contact Us

Thank you for working with us to ensure that CountyCare members receive quality care at the right time and in the right setting. If you have any questions or would like additional information, please contact CountyCare Provider Services at countycareproviderservices@cookcountyhhs.org or your assigned provider relations representative. You can also reach CountyCare Provider Services by phone at 312-864-8200, option 3.