Reconsideration Review Request Form
Fax – 1- 855-677-3747

Request Date: ______________________

RECIPIENT INFORMATION

Recipient Name: Last, First, Middle

____

Date of Birth: ☐☐/☐☐/☐☐

Medicaid ID #: ☐☐☐☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

REQUESTING PROVIDER INFORMATION

Requestor's Name: ________________________________

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

email: ____

Provider Name:

____

Provider's Medicaid ID #: ☐☐☐☐☐☐☐☐☐
(required)

ORDERING PROVIDER'S NAME

Ordering Provider's Name: Last, First, Middle

____

Phone #: (☐☐☐)☐☐☐ -☐☐☐☐

Fax #: (☐☐☐)☐☐☐ -☐☐☐☐

Medicaid #: ☐☐☐☐☐☐☐☐☐

(required)

NPI: ☐☐☐☐☐☐☐☐☐☐

FI License # ☐☐☐☐☐☐☐

TYPE OF SERVICE

Indicate the service type for Recipient:

☐ Ambulatory Surgery
☐ Vision/Optometry
☐ Hearing
☐ ITP Pump
☐ Chiropractic
☐ Special Services
☐ Advanced Diagnostic Imaging
Other (explain) ________________________________

RECONSIDERATION INFORMATION

Date of denial notification: ☐☐/☐☐/☐☐

Date of Start of Service: ☐☐/☐☐/☐☐

Date of completion of services , if applicable: ☐☐/☐☐/☐☐

Are you submitting additional clinical information? Yes ☐ No ☐

REASONS FOR DISAGREEMENT WITH THE DENIAL DETERMINATION

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Recipient Medicaid ID#: ______________________________

Recipient Last, First, Middle Name: _________________________________ Date of Birth: _______________

Additional Information