

Request Date: _____

RECIPIENT INFORMATION

Recipient Name: Last, First, Middle

Medicaid ID #:

Date of Birth: //

Sex: Age:

REQUESTOR AND PROVIDER INFORMATION

PHYSICIAN'S NAME

Requestor's Name: _____

Physician's Name: Last, First, Middle

Requested by: Facility Physician Recipient/Representative

Phone #: () -

Phone #: () -

Ext.

Fax #: () -

Fax #: () -

Medicaid #:

email: _____

NPI:

Provider Name: _____

FI License #:

Provider's Medicaid ID #:

TYPE OF SERVICE

Indicate the service the Recipient is to/was receiving:

- Acute Inpatient
- Inpatient Rehabilitation

RECONSIDERATION INFORMATION

Date of denial notification: //

Date of Admission/Start of Service: / /

Date of Discharge, if applicable: / /

Are you submitting additional clinical information? Yes No

REASONS FOR DISAGREEMENT WITH THE DENIAL DETERMINATION

Recipient Medicaid ID Number:

Recipient Last, First, Middle Name:

Date of Birth:

ADDITIONAL COMMENTS: