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

Health SOLUTIONS

Request Date: _____

RECIPIENT INFORMATION

Recipient Name: Last, First, Middle

_____

Date of Birth: ☐☐/☐☐/☐☐

Medicaid ID #: ☐☐☐☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

REQUESTOR AND PROVIDER INFORMATION

Requestor's Name: _____

Requested by: ☐ Facility ☐ Physician ☐ Recipient/Representative

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

email: _____

Provider Name:

_____

Provider's Medicaid ID #: ☐☐☐☐☐☐☐☐☐

PHYSICIAN'S NAME

Physician's Name: Last, First, Middle

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

Medicaid #: ☐☐☐☐☐☐☐☐☐

NPI: ☐☐☐☐☐☐☐☐☐☐

FI License #: ☐☐☐☐☐☐☐

TYPE OF SERVICE

Indicate the service the Recipient is to/was receiving:

☐ Inpatient Med/Surg
☐ Inpatient Rehabilitation
☐ Outpatient Surgery
☐ Home health visits
☐ Private Duty Nursing
☐ Personal Care Services
☐ CDC+
☐ Physical Therapy
☐ Speech-language Pathology
☐ Occupational Therapy

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

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Recipient Medicaid ID Number: ☐☐☐☐☐☐☐☐☐☐

Recipient Last, First, Middle Name: _____ Date of Birth: ☐☐/☐☐/☐☐

ADDITIONAL COMMENTS: