



PROVIDER RECONSIDERATION FORM

RETURN TO: HOV SYSTEMS, P.O. BOX 5028, TROY, MI 48007-5028

Inquiry Reason (Check appropriate box)

<input type="checkbox"/> Reconsideration/Maximum Allowance	<input type="checkbox"/> Provider Error
<input type="checkbox"/> Reconsideration/Denied Services	<input type="checkbox"/> Plan Payment Error
<input type="checkbox"/> Status/Second Request	
<input type="checkbox"/> Other:	

Required Information:

Patient _____ Member ID No. _____

Provider Name _____ Provider ID No. _____

Phone _____ Fax _____

Provider Remarks (Please print and attach documentation)

Claim #	DOS#	Billed Amount	Patient's Account #

Briefly describe problem and action requested:

Documentation Attached _____ # of pages Notes/Treatment sheet

Corrected Claim Referral Other _____

Plan Comments:

NOTES: ► Only one (1) member/patient inquiry per form. ► Claims form(s) required per inquiry with Box 19 marked "reconsideration". ► Submit form as cover page with documentation attached as necessary.

Signature _____ Date _____