PROVIDER RECONSIDERATION FORM

RETURN TO: CLAIMS, P.O. BOX 5806, TROY, MI 48007-5806

Inquiry Reason (Check appropriate box)

- ❑ Reconsideration/Maximum Allowance
- ❑ Reconsideration/Denied Services
- ❑ Status/Second Request
- ❑ Other:
- ❑ Provider Error
- ❑ Plan Payment Error

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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:

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❑ Documentation Attached __________ # of pages ❑ Notes/Treatment sheet

❑ Corrected Claim ❑ Referral ❑ Other__________________________

Plan Comments:

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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 ________________