Medical Claim Reconsideration Request Form

Patient Information

Patient Name

Date of Birth

Member ID

Phone Number

Provider Information

Provider Name

Provider NPI

Provider Phone

Provider Email

Claim Information

Claim Number

Date of Service

Billed Amount

Reason for Reconsideration

Describe the reason for your reconsideration request

Additional Information (Optional)

Provide any supporting details or documentation

Certification

☐ I attest that the above information is accurate and complete to the best of my knowledge.

Requester Name

Date