

1. This form helps communicate your exact request in order to provide better service for you.
Submit legible copies of CMS 1500 or UB04 claim form.
2. Check the most appropriate box below for type of review requested.
3. **Use only one form per reconsideration request.**

Date: _____

Original Claim# _____

Contact Person _____

Phone Number _____

Mail to:

**Community Care Plan
Attention: Claims Review
P.O. Box 849029
Pembroke Pines, FL 33084**

The following fields are required or request for reconsideration will be returned.

<p>MEMBER I.D. NUMBER</p> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> </tr> </table> <p> <input type="checkbox"/> MMCP/ MCHP <input type="checkbox"/> PCC/UPFUND <input type="checkbox"/> CCP <input type="checkbox"/> CCP/CCP HSA (Medicaid MMA) (Employee Plans) <input type="checkbox"/> BRHPC </p>											<p>MEMBER NAME</p> <p>First: _____</p> <p>Last: _____</p> <p>DOB: _____</p>

Authorization Denials:

- ☐ Claim denied for “no auth” but services do not require an authorization.
☐ Services were authorized, please review this auth number: _____
☐ Specific services were not authorized, but were medically necessary -
 See enclosed supporting documentation & reconsideration letter describing the situation.

Other Denials:

- ☐ Member Not Eligible on DOS ☐ COB Information Requested – see attached
☐ Untimely filing – see proof attached ☐ Records Requested – see enclosed records
☐ Invoice Requested – see attached
☐ BUND/CMPD – records attached to substantiate procedure(s) for reconsideration

Provider Corrected Claim

- ☐ Units
☐ Coding (DX/CPT/HCPCS/RevCode/POS)
☐ Member

OTHER: Please Describe

Corrected Claim (Plan Data Entry Error)

- ☐ Units Paid Incorrectly
☐ Service Code Missing / Paid Incorrectly
☐ Payment Sent to Wrong Address
☐ Payment Made to Wrong Provider