REQUEST FOR RECONSIDERATION

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.

MEMBER I.D. NUMBER ☐☐☐☐☐☐☐☐☐☐☐ ☐ **MMCP/ MCHP** ☐ **PCC/UPFUND** ☐ **CCP (Medicaid MMA)** ☐ **CCP/CCP HSA (Employee Plans)** ☐ **BRHPC** ☐ **BCG**	**MEMBER NAME** **First**: _____ **DOB**: _____ **Last**: _____

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
☐ Untimely filing – see proof attached
☐ Invoice Requested – see attached
☐ COB Information Requested – see attached
☐ Records Requested – see enclosed records
☐ BUND/CMPD – records attached to substantiate procedure(s) for reconsideration

Provider Corrected Claim
☐ Units
☐ Coding (DX/CPT/HCPCS/RevCode/POS)
☐ Member

Corrected Claim (Plan Data Entry Error)
☐ Units Paid Incorrectly
☐ Service Code Missing / Paid Incorrectly
☐ Payment Sent to Wrong Address
☐ Payment Made to Wrong Provider

OTHER: Please Describe
_____
_____
_____
_____