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
- □ 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

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

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.

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

Original Claim#_________________________  
Contact Person _________________

Phone Number ________________________