



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 841309
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: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p> <input type="checkbox"/> MMCP/ MCHP <input type="checkbox"/> PCC/UPFUND <input type="checkbox"/> CCP (Medicaid MMA) <input type="checkbox"/> CCP/CCP HSA (Employee Plans) <input type="checkbox"/> BRHPC </p>																					<p>MEMBER NAME</p> <p>First: _____</p> <p>Last: _____</p> <p style="text-align: right;">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
- Untimely filing – see proof attached
- Invoice Requested – see attached
- BUND/CMPD – records attached to substantiate procedure(s) for reconsideration
- COB Information Requested – see attached
- Records Requested – see enclosed records

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