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)	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
_____
_____
_____
_____