Reconsideration / Appeal Request

NOTE: Completion of this form is mandatory. To obtain a review, submit this form as well as information that will support your appeal, to include a copy of the EOB denial and clean claim.

Please provide the following information. *(This information may be found on the authorization form.)*

Today's Date:	Detainee's Alien ID #:	Type of Care: **[Medical or Dental]**

Detainee's First Name:	Detainee's Last Name:	Detainee's Date of Birth:

Provider Name:	TIN:	Provider Group (*If Applicable*):
Contact Name and Title:		
Contact Address:		
Contact Phone Number:	Contact Fax:	Contact Email Address:

(You may use this form to appeal multiple dates of service for the same detainee.)

CPT Code(s):	MedPAR/Referral/Authorization Number:	Date(s) of Service:
Initial Denial Date(s) on Explanation of Benefits (EOB):	CPT Code(s) Disputed:	
Explanation of Your Request *(please use additional pages if necessary.)*:		