Reconsideration Review Request Form
   Fax- 855-440-3747

eq·Health
s o l u t i o n s

Request Date: _____

CLIENT INFORMATION

Client Name: Last, First, Middle

_____

Date of Birth: ____ / ____ / ____

Medicaid ID #: ☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

REQUESTOR AND PROVIDER INFORMATION

Requestor's Name: _____

Requested by: ☐ Ordering Physician   ☐ Servicing Provider

Phone #: (☐☐☐) ☐☐☐ - ☐☐☐☐

Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐ - ☐☐☐☐

email: _____

Provider Name:

_____

Provider's Medicaid ID #: ☐☐☐☐☐☐☐☐

TYPE OF SERVICE

Document the service the Recipient is to/was receiving:

RECONSIDERATION INFORMATION

Date of denial notification: ☐☐ ☐☐ ☐☐

PAR span (begin & end dates):

From: ____ / ____ / ____   **To:** ____ / ____ / ____

Are you submitting additional clinical information? Yes   No

REASONS FOR DISAGREEMENT WITH THE DENIAL DETERMINATION

Effective: 9/1/15