



RECONSIDERATION REQUEST

Complete one form for each claim or referral you would like reconsidered.

Provider: Please complete this form in its entirety.

Date:*	Date of EOB/Denial Letter:*
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*Submit Reconsideration request within 365 days from the **Date of Service** to Hometown Health to resolve a claim.

Physician Name:		Provider Contact/ Telephone #:
Office Practice Name:		Specialty:
Member Name:	Member #:	Date of Service:
Claim # :	Total Charge:	Referral #:

To help avoid delay of your reconsideration, please include the following items as necessary.

CLAIMS

REFERRALS

Hometown Health Payment Policy, include Medical Records

Not Medically Necessary, include Medical Records

No Prior Authorization, include Proof of Authorization

Not a Covered Benefit, include Medical Records

Amount Paid, include any supporting documentation

Nonparticipating Vs Participating

Amount Allowed, include any supporting documentation

Referral Date Range inconsistent with Claim

Timely Notification

No Authorization

Capitation Vs Fee for Service

Other

Other

To trace a claim, search on HealthConnect. Use this form only to request a reconsideration.

Additional Reconsideration Information:

Send this form and required documents to:

**Hometown Health
Attn: Provider Reconsiderations
830 Harvard Way
Reno, NV 89502
(775) 982-3741 - FAX**