

## RECONSIDERATION REQUEST

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

*Provider: Please complete this form in its entirety*

<b>Date:</b>	<b>Date of EOB/Denial Letter:</b>
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<b>Physician Name:</b>		<b>Provider Contact/Phone#:</b>	
<b>Practice Name:</b>		<b>Specialty:</b>	
<b>Member Name:</b>	<b>Member #:</b>	<b>Date of Service:</b>	
<b>Claim #:</b>	<b>Billed Amount:</b>	<b>Referral #:</b>	

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

**CLAIMS**

**REFERRALS**

<p>Hometown Health Payment Policy <i>(Include Medical Records)</i> <input type="checkbox"/></p> <p>No Prior Authorization <i>(Include Proof of Authorization)</i> <input type="checkbox"/></p> <p>Amount Paid <i>(Include any supporting documentation)</i> <input type="checkbox"/></p> <p>Amount Allowed <i>(Include any supporting documentation)</i> <input type="checkbox"/></p> <p>Timely Notification <input type="checkbox"/></p> <p>Capitation vs. Fee for Service <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>Not Medically Necessary <i>(Include Medical Records)</i> <input type="checkbox"/></p> <p>Not a Covered Benefit <i>(Include Medical Records)</i> <input type="checkbox"/></p> <p>Nonparticipating vs. Participating <input type="checkbox"/></p> <p>Referral date range inconsistent with claim <input type="checkbox"/></p> <p>No Authorization <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>
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**To trace a claim, search on Health Connect. Use this form only to request a reconsideration**

<b>Additional Reconsideration Information:</b>

Send this form and any required documents to:

Fax # 775-982-3741

**Hometown Health  
Attn: Provider Reconsiderations  
10315 Professional Circle  
Reno, NV 89521**