# Prior Authorization Reconsideration Request

**Purpose:** Request a reconsideration on any denied services on an authorization request.

**Required Attachments**: Documentation you would like considered under this reconsideration request.

**Notes:**
- Services are dependent on medical necessity.
- Please review the Billing Guidelines for the appropriate provider type available on the Providers Billing Information webpage.

**Upload this form and required attachments through the Provider Web Portal.**

**Questions? Call:** (800) 525-2395

**DATE OF REQUEST:** _____ /_____ /_____

**Prior Authorization Number pertaining to services to be reconsidered:** _____

| **SECTION I: RECIPIENT INFORMATION** | |
|---|---|
| Recipient Name: | Date of Birth: |
| Recipient Medicaid ID: | Phone: |
| Recipient Mailing Address: | |
| **SECTION II: FACILITY/PROVIDER INFORMATION** | |
| Name: | NPI: |
| Phone: | Fax: |
| Physical Address: | |
| Name of Person Completing This Form: | |
| Professional Title of Person Completing This Form: | |
| Contact Phone: | Contact Email Address: |
| **SECTION III: DENIED SERVICES/DATES/UNITS TO BE RECONSIDERED** | |
| HCPCS/CPT/CDT/Rev Code: | |
| Dates of Service to be Reconsidered: Begin Date:_____ End Date: _____ | |
| Number of Denied Days or Units: | |
| **SECTION IV: ADDITIONAL INFORMATION** Additional information is required to process your request. Please include additional information (including documentation) that supports your original prior authorization request, but that was NOT submitted with the original request.* | |
| | |

* Give a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered. Include only the medical records that support the medical necessity issues identified in the synopsis. Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*