OptimaHealth

PROVIDER RECONSIDERATION FORM

RETURN TO: HOV SYSTEMS, P.O. BOX 5028, TROY, MI 48007-5028

Inquiry Reason (Check appropriate box)

- ❑ Reconsideration/Maximum Allowance
- ❑ Reconsideration/Denied Services
- ❑ Status/Second Request
- ❑ Other:
- ❑ Provider Error
- ❑ Plan Payment Error

Required Information:

Patient _____Member ID No._____

Provider Name _____Provider ID No. _____

Phone _____Fax _____

Provider Remarks (Please print and attach documentation)

Claim #	DOS#	Billed Amount	Patient's Account #

Briefly describe problem and action requested:

_____

_____

❑ Documentation Attached _____ # of Pages ❑ Notes/Treatment Sheet

❑ Corrected Claim ❑ Referral ❑ Other_____

Plan Comments:

_____

_____

NOTES: ► Only one (1) Member/patient inquiry per form. ► Claims form(s) required per inquiry with Box 19 marked "reconsideration". ► Submit form as cover page with documentation attached as necessary.

Signature _____ Date _____