OptimaHealth

Hours of Operation (EST) 8 AM to 4:30 PM
Monday through Friday

Use this form to request Reconsideration of a Denied Pre-authorization.

Fax completed form and supportive clinical data to:

757-552-7176 Attn: Pre-authorization Reconsideration Specialist

**** This form is not used for claims reconsideration****

For reconsideration of denied claims, please visit: http://providers.optimahealth.com/billing

Date of Denial: _____ (Date listed on the denial letter)

Optima:

*__Family Care Members__-must be submitted within 30 days of the date listed on the denial letter

*__Commercial Members__-must be submitted within 45 days of the date listed on the denial letter

Please check service(s) type previously denied

_____ Advanced Imaging (MRI/CT/PET) _____ Genetic Testing _____DME/Prosthetics

_____ Inpatient (Pre-Service) ____Other

Member's Name / Last, First	Member's ID / Policy #	Date of Birth	Today's Date

Requesting Provider (Full Name): _____

The following information is required to process your reconsideration request:

Diagnosis Code(s):_____

Procedure Codes Denied: _____/_____/_____/_____

Additional Clinical Data (**information not submitted with original request**) that you believe supports approval:

IE: Medical Records, Test Results, Medications, Failed Treatments or Therapies, Evidence Based Research

To expedite processing, please **do not include the clinical documents submitted with the original request.

** *You may check the status on* Optimahealth.com *or by calling Provider Relations at 1-800-229-8822 Option 4*

Person Completing this Form: _____

Phone: _____ / ext.:_____ Fax: _____