OptimaHealth

Hours of Operation (EST) 8 AM to 5:00 PM
Monday through Friday

This form is to request **COMMERCIAL** reconsideration of a **Denied pre-authorization**

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

This request must be within **five days** of the date on the denial letter

Fax completed form and supportive clinical data to:
Pre-authorization Reconsideration Specialist at 757-431-7757

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

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

Please check the 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 the original request**) that 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: _____