Reconsideration Review Request Form
Fax- **1-866-940-4288**

eq·Health solutions

Request Date: _____

CLIENT INFORMATION

Client Name: Last, First, Middle

_____

Date of Birth: / /

Medicaid ID #: ☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

REQUESTOR AND PROVIDER INFORMATION

Requestor's Name: _____

Requested by: ☐ Ordering Physician ☐ Servicing Provider

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

email: _____

Provider Name:

_____

Provider's Medicaid ID #: ☐☐☐☐☐☐☐☐

TYPE OF SERVICE

Document the service the Recipient is to/was receiving:

RECONSIDERATION INFORMATION

Date of denial notification: ☐☐ ☐☐ ☐☐

PAR span (begin & end dates):

From: / / **To:** / /

Are you submitting additional clinical information? Yes No

REASONS FOR DISAGREEMENT WITH THE DENIAL DETERMINATION