INSTRUCTIONS FOR COMPLETING THE RECONSIDERATION REVIEW REQUEST FORM

THIS FORM CAN BE COMPLETED BY THE RECIPIENT OR LEGAL REPRESENTATIVE, THE PROVIDER OF SERVICES, OR THE ATTENDING OR ORDERING PHYSICIAN

REQUEST DATE

- ***Request Date***- Enter the date of submission of the request.

RECIPIENT INFORMATION

- ***Recipient Name*** - Enter the recipient's last, first and middle name as it appears on the FL Medicaid ID card.
- ***Date of Birth*** - Enter the month, date, and year of the recipient's birth.
- ***Recipient Medicaid Number*** - Enter the recipient's ten (10) digit number as it appears on the Fl Medicaid ID card.
- **Sex** - Indicate the sex of the recipient.
- ***Age*** - Enter the age of the recipient at the time service is to be/was rendered.

REQUESTOR AND PROVIDER INFORMATION

- ***Requestor's Name*** - Enter the name of the individual requesting the reconsideration review.
- ***Requested by*** – Indicate whether the requesting party is the facility, the physician or the recipient/representative. If the request is from multiple parties, check all that apply.
- ***Requestor's Telephone Number and Ext.*** - Enter the telephone number of the requestor including area code and extension number.
- ***Requestor's Fax Number*** - Enter the fax number of the requestor including the area code.
- ***Requestor's e-mail*** - Enter the e-mail address of the requestor.
- ***Provider's Name*** - Enter the name of the hospital, home health services provider, or physical, occupational or speech-language pathology provider who requested prior authorization of services.
- ***Provider's FL Medicaid Provider Number*** - Enter the provider's Florida Medicaid provider number.

PHYSICIAN INFORMATION

- ***Physician's Name*** - Enter the name of the attending or ordering physician, last, first and middle name.
- ***Physician's Phone Number*** - Enter the phone number of the physician.
- ***Physician's Fax Number*** - Enter the fax number of the physician.
- ***Physician's Identification Number(s)*** - *Enter one or more of the following:*
  - ***Physician's FL Medicaid Provider Number*** - Enter the physician's Florida Medicaid provider number
  - ***Physician's NPI*** **–** Enter the physician's National Provider Identifier number
  - ***Physician's FL License Number*** - Enter the physician's Florida license number.

RECIPIENT INFORMATION TYPE OF SERVICE

- ***Type of Service*** – Indicate the type of services which were denied.

RECONSIDERATION INFORMATION

- **Date of Denial Notification –** Enter the date of notice from the top right corner of the letter from eQHealth Solutions.
- ***Date of Admission/Start of Service*** – Enter the (proposed) date of admission or start of services.

- ***Date of Discharge*** – If the recipient is no longer receiving services, enter the date of discharge.
- ***Submission of Additional (clinical) Information*** – Indicate whether additional information that is not included on the form will be submitted to eQHealth Solutions.

REASONS FOR DISAGREEMENT WITH THE DENIAL DETERMINATION

- Provide the reason for disagreement with the denial, including any clinical/medical information to support the request for reconsideration.

ADDITIONAL COMMENTS

- Use this page as a supplement to page one of the form to provide additional comments when additional space is needed to document the reason(s) for disagreement with the denial **determination**.