RECONSIDERATION REQUEST

Complete <u>one</u> form for each claim or referral you would like reconsidered

Provider: Please complete this form in its entirety

Date:	**Date of EOB/Denial Letter:**

*Submit Reconsideration request within **<u>365</u>** days from the **Date of Service** to Hometown Health to resolve a claim

Physician Name:	**Provider Contact/Phone#:**	
Practice Name:	**Specialty:**	
Member Name:	**Member #:**	**Date of Service:**
Claim #:	**Billed Amount:**	**Referral #:**

To help avoid delay of your reconsideration, please include the following items as necessary

<u>CLAIMS</u>

- Hometown Health Payment Policy (*Include Medical Records*) ☐
- No Prior Authorization (*Include Proof of Authorization*) ☐
- Amount Paid (*Include any supporting documentation*) ☐
- Amount Allowed (*Include any supporting documentation*) ☐
- Timely Notification ☐
- Capitation vs. Fee for Service ☐
- Other ☐

<u>REFERRALS</u>

- Not Medically Necessary (*Include Medical Records*) ☐
- Not a Covered Benefit (*Include Medical Records*) ☐
- Nonparticipating vs. Participating ☐
- Referral date range inconsistent with claim ☐
- No Authorization ☐
- Other ☐

To trace a claim, search on Health Connect. Use this form only to request a reconsideration

Additional Reconsideration Information:

Send this form and any required documents to:

Hometown Health
Attn: Provider Reconsiderations
10315 Professional Circle
Reno, NV 89521