

# Reconsideration / Appeal Request

**NOTE:** Completion of this form is mandatory. To obtain a review, submit this form as well as information that will support your appeal, to include a copy of the EOB denial and clean claim.

*Please provide the following information. (This information may be found on the authorization form.)*

Today's Date:	Detainee's Alien ID #:	Type of Care: <b>[Medical or Dental]</b>
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Detainee's First Name:	Detainee's Last Name:	Detainee's Date of Birth:
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Provider Name:	TIN:	Provider Group <i>(If Applicable)</i> :
Contact Name and Title:		
Contact Address:		
Contact Phone Number:	Contact Fax:	Contact Email Address:

*(You may use this form to appeal multiple dates of service for the same detainee.)*

CPT Code(s):	MedPAR/Referral/Authorization Number:	Date(s) of Service:
Initial Denial Date(s) on Explanation of Benefits (EOB):		CPT Code(s) Disputed:
Explanation of Your Request <i>(please use additional pages if necessary.)</i> :		