Acentra HEALTH

# Reconsideration Request Form for HFS Participants

| RECONSIDERATION TYPE: | | *EXPEDITED (Patient in hospital)* | | *STANDARD* |
|---|---|---|---|---|

## PARTICIPANT INFORMATION

Recipient ID # (RIN): | Gender: | Age: | Date of Birth: (xx/xx/xxxx)

Participant Name: (First) (MI) (Last)

## PROVIDER INFORMATION

Hospital Medicaid ID: | Attending Phys. Medicaid #:

Hospital Name: | Attending Physician Name: (First) (MI) (Last)

Physician Contact Requested? ☐ Yes ☐ No

If "Yes", provide Treating Physician Information: (no third-party contact) | Name: Phone Number:

## REQUEST INFORMATION

Request Date: | Requested By: ☐ Hospital ☐ Physician

Request Method: ☐ Fax ☐ Mail | Requestor Name:

**Fax: 1-800-418-4039 Attn: Denial/Reconsideration** | Requestor Telephone #: | Ext.

**Mail**: Acentra Health, 500 Waters Edge Lane, Suite 125, Lombard, IL 60148 Attn: Denial/Reconsideration Coordinator

## RECONSIDERATION INFORMATION

Date of Denial Notification:

Date of Admission: | Date of Discharge:

Rationale / Medical Reason for Disagreement (type in text box below):

| **Is additional information submitted?** | ☐ Yes | ☐ No |
|---|---|---|

***IMPORTANT**: Please complete this form and submit it with additional information or documentation to support the medical necessity of the denied date(s) of service only. **DO NOT fax documentation more than 10 pages. If your documentation is greater than 10 pages, please submit by mail.***

*An approved request for Certification of Admission / Continued Stay does not guarantee payment from HFS. When an approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service and to confirm the patient's continuing need for service.*