Hometown Health | Senior Care Plus

# RECONSIDERATION REQUEST

**Complete ONE form for each claim or referral you would like reconsidered.**

PROVIDER: *Please complete this form in its entirety.*

Date _____ Date of EOB/Denial Letter _____

Physician Name _____ Provider Contact/Phone Number _____

Practice Name _____ Specialty _____

Member Name _____ Member Number _____ Date of Service _____

Claim Number _____ Billed Amount _____ Referral Number _____

## TO HELP AVOID DELAY OF YOUR RECONSIDERATION, PLEASE INCLUDE THE FOLLOWING ITEMS AS NECESSARY

### CLAIMS

- ☐ 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

### REFERRALS

- ☐ 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 EPICCARE LINK. USE THIS FORM ONLY TO REQUEST A RECONSIDERATION.

| Please explain why you disagree with the initial determination: |
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SEND THIS FORM AND ANY REQUIRED DOCUMENTS TO: **Recons@HometownHealth.com**
you can also fax to **775-982-3741** or drop-off in-person at
**Hometown Health • 10315 Professional Cir. • Reno, NV 89521**
ATTENTION: **Provider Reconsideration**