CULINARY PROVIDER RECONSIDERATIONS FORM

DATE: ______________________________

CLAIM #: ______________________________

PATIENT NAME: ______________________________

DATE OF SERVICE: ______________________________

CPT/HCPCS CODE (S) REQUIRING REVIEW: ____________________

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PROVIDER TIN: ______________________________

PROVIDER NAME: ______________________________

CONTACT PERSON: ______________________________

PHONE NUMBER: ______________________________

REASON FOR REQUEST (brief description of the issue (s))

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ATTACHMENTS: Check all that apply

☐ Copy of Claim ☐ Operative Report ☐ Medical Records
☐ CCI guidelines ☐ Contract Language

☐ Other ____

Provider Reconsiderations Department
P.O. Box 44216
Las Vegas, NV 89116