Culinary Health Fund
Administrative Services, LLC

CHF PROVIDER RECONSIDERATION / ADDITIONAL INFO SUBMISSION FORM

DATE: _____

CLAIM #: _____

MEMBER ID#: _____

PATIENT NAME: _____

DATE OF SERVICE: _____

CPT/HCPCS CODE(S) REQUIRING REVIEW: _____

PROVIDER TIN: _____

PROVIDER NAME: _____

CONTACT PERSON: _____

CONTACT PHONE #: _____

REASON FOR REQUEST: (brief description of the issue[s])**:**

_____

_____

_____

_____

_____

ATTACHMENTS: Check all that apply:

- ☐ Copy of Claim
- ☐ Primary Insurance EOB
- ☐ Operative Report
- ☐ Itemization
- ☐ Medical Records
- ☐ Other _____

Culinary Health Fund
P.O. Box 211471
Eagan, MN 55121