

Request for Reconsideration Ancillary Therapy Billing

A nursing facility that disagrees with the Healthcare Review Corporation's denial for ancillary therapy billing may request a reconsideration. All facility requests for reconsideration will be made in writing using this form, within seven (7) days of the date the facility is notified that a selected ancillary therapy modality has not been approved by the review agency.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Facility Name: _____

Facility Medicaid Provider Number: _____

Facility Telephone Number: _____

Facility Address: _____

Resident's Name: _____

Resident's Medicaid Number: _____

Effective Date of the Denial: _____

IN ORDER TO ESTABLISH A BASIS FOR RECONSIDERATION:

- 1) Enclose a copy of the resident Ancillary Services Nursing Facility Determination form.
- 2) Write a brief description of the basis for your disagreement with the denial. (Attach rationale to this form.)
- 3) Attach documentation establishing that the needs of the resident at the time of the denial justify ancillary therapy billing.

I signify by my signature that these statements are correct and factual to the best of my knowledge.

Signature: _____ Date: _____

Title: _____

Mail to: Attn: Field Review Supervisor
 Healthcare Review Corporation
 9200 Shelbyville Rd., Ste. 700
 Louisville, KY 40222