REQUEST FOR RECONSIDERATION OF DISCHARGE

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

☐ Request for reconsideration due to discharge from the Office for Children with Special Health Care Needs (OCSHCN) for non-payment of an outstanding account balance.

☐ Request for reconsideration due to discharge from OCSHCN for exceeding the three (3) allowable resubmissions of an application to OCSHCN.

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ EMAIL: _____

REASON OR JUSTIFICATION FOR RECONSIDERATION:
(USE BACK FOR ADDITIONAL SPACE) _____
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SIGNATURE: _____ DATE: _____

Please return completed form and any supporting documentation (bank statements, provider statements, original receipts showing amount paid) to:

Attention: Provider Relations
Office for Children with Special Health Care Needs
310 Whittington Parkway Suite 200
Louisville, KY 40222