Provider Request for Reconsideration of an Action

Please use this form to request reconsideration of an Alliance provider action as more fully described in the Provider Manual, Section IX

Requests for Reconsideration should include all relevant documentation supporting your request and a clear explanation justifying reconsideration. The following should be completed in ink or typewritten and be easily legible. **An electronic version** of this form can be found at https://www.alliancehealthplan.org/providers/publications-forms-documents.

Forms with supporting documentation should be submitted within twenty-one (21) calendar days of receipt or first attempted delivery of the notification letter to COMPLIANCE-PROVIDER RECONSIDERATIONS, Alliance Health, 5200 West Paramount Parkway, Suite 200, Morrisville, NC 27560.

Please do not use this form for reevaluation of authorization issues or claim denials. For instruction regarding these types of issues, please refer to the Provider Operations Manual which can be found at: https://www.alliancehealthplan.org/providers/publications-forms-documents.

Provider/Agency Name: _____

Contact Name for this Request: _____ Signature: _____

Date of Action: _____ Type of Action: _____

Issue(s) to be Reconsidered (please use a separate row for each Issue you are requesting a Reconsideration Review)	**Alliance Action Applied** (if payback, include Payback amount to be reconsidered)	**Reason(s) for Reconsideration** (please be specific in regard to the reason and justification for Reconsideration for each issue listed)	**Supporting Documentation Attached** (ex. service documentation, policy and procedure)

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Please attach additional sheets and/or documentation as needed.