Sentara® Health Plans

Provider Reconsideration Form

Completion of this form is required or subject to rejection and return to provider

Return to: Medical Claims, PO Box 8203, Kingston, NY 12402

Inquiry Reason (Check appropriate box)

Claims	Clinical
☐ Underpayment ☐ Overpayment ☐ Approved Authorization Payment Issue	☐ Coding/Bundling ☐ Retro-authorization Review

Required Information:

Patient Name:	Member ID Number:
Provider Name:	Provider ID Number:
Phone Number:	Fax Number:
Response Address:	City/State/Zip:

Provider Remarks (Please print and attach documentation)

Claim#	DOS#	Billed Amount	Patient's Account#

Briefly describe problem and action requested:

_____

_____

☐ Documentation Attached _____number of pages

☐ Other _____

Notes: Only one (1) member/patient inquiry per form. Submit form as cover page with documentation attached as necessary.

Signature _____ Date: _____