Sentara Health Plans

PO Box 66189
Virginia Beach, VA 23466

Use this form for **Reconsideration of a Denied Pre-authorization**. Fax completed form and supportive clinical data to 1-888-576-9675 Attn: Pre-authorization Reconsideration Specialist

****** This form is not used for claims reconsideration******

For reconsideration of denied claims, please visit: sentarahealthplans.com/providers/billing-and-claims.

What is the date of the Adverse Benefit Determination (denial letter)? _____

***Commercial Plans** - must be submitted within 45 days of the date listed on the denial letter.

Please check service(s) type previously denied:

☐ Advanced Imaging (MRI/CT/PET)

☐ Other

☐ Inpatient (Pre-service)

☐ DME/Prosthetics

☐ Outpatient Services

Member's Name/Last, First	Member's ID/ Policy #	Date of Birth	Today's Date

Requesting Provider (Full Name): _____

The following information is required to process your reconsideration request:

Diagnosis Codes: _____

Procedure Codes Denied: _____/_____/_____/_____

Additional Clinical Data (**information not submitted with original request**) that you believe supports approval (i.e., medical records, test results, medications, failed treatments or therapies, evidence-based research):

Person Completing This Form: _____

Phone: _____ Ext: _____ Fax: _____