75 Vanderbilt Ave Suite 700 Staten Island NY 10304 1-844-CPHL-CARES www.centersplan.com

## Claim Reconsideration Request

This form shall be used to request the reconsideration of a claim for which a decision has been issued by Centers Plan and is not intended for claim inquiries or new claim submissions.

Be specific when completing the **DESCRIPTION OF ISSUE** and provide any additional information to support your dispute. Please include a copy of the explanation of payment (EOP) aka remittance advice.

You can mail or fax the completed form to the attention of the Claims Department at the address below or Fax to: 347-802-4308.
For follow up inquiries related to your reconsideration please contact us at 1-844-292-4211

Provider Name: ______________________________ Tax ID No. ______________________

Provider Service Address: ____________________________________________________

Claim ID: ____________________________

| Member Name | DOB | Service From | Service To | Charges | Prior Paid Amount |
|---|---|---|---|---|---|
| CPHL ID | __/_/_____ | __/_/_____ | __/_/_____ | | |

Description of issue:

______________________________________________________________________

______________________________________________________________________

Claim ID: ____________________________

| Member Name | DOB | Service From | Service To | Charges | Prior Paid Amount |
|---|---|---|---|---|---|
| CPHL ID | __/_/_____ | __/_/_____ | __/_/_____ | | |

Description of issue:

______________________________________________________________________

______________________________________________________________________

Claim ID: ____________________________

| Member Name | DOB | Service From | Service To | Charges | Prior Paid Amount |
|---|---|---|---|---|---|
| CPHL ID | __/_/_____ | __/_/_____ | __/_/_____ | | |

Description of issue:

______________________________________________________________________

______________________________________________________________________

Contact Name:____________________________ Phone #: ____________________________

Signature:______________________________ Date: ______________________________