KAISER PERMANENTE®

RECONSIDER/RESUBMITTAL FORM

Please reconsider the following information for the claims listed below.

Date: _____

Provider: _____

Tax ID: _____

Contact Name: _____

Contact Number: _____

Contact Email (optional): _____

Member/Patient Name: _____

Member ID Number:_____

Date of Service:_____

Claim #: _____

Billed Amount:_____

Please check the appropriate box for reconsideration / resubmittal below:

- ☐ No authorization on file
- ☐ Denied in Error
- ☐ Denied (included in global)
- ☐ Timely Filing
- ☐ Incorrect Payment
- ☐ Other

Please explain the nature of your reconsideration/resubmittal:

_____

_____

_____

_____

_____

Authorized Signature: _____

Date: _____