HCHCP RECONSIDERATION FAX FORM

Fax to: 1- 866- 889- 6516 **Date:**

1. Member Subscriber Number (10 digit ID):	2. Member Last Name:	3. Member First Name:
4. Case Reference Number:		
5. Primary Procedure CPT Codes:	6. Primary Procedure CPT Codes Description:	
Please note- clinical information may be attached to form, this is not mandatory		
7. Please include New/Additional Information. Presenting Signs and Symptoms/Treatment/History/Abnormal Findings/Reports:		

8. Physician Office Fax Number: _____

9. Physician Office Telephone (Direct name and extension): _____