**REQUEST FOR PRE-PAY REVIEW PROVIDER RECONSIDERATION**

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| Please use this form to submit a Pre-payment Reconsideration. If this is a second level, you will need to include new information that may change the outcome of the initial decision.  **Timely Filing:** The provider has 24 months from the notification date of denial.  Please complete the fields below and **email**, **fax, or mail** this form with supporting documentation to:   |  |  | | --- | --- | | **Attn:** Pre-Payment Reconsideration  **Email:** pre-pay-inbox@kp.org  **FAX**: 877-779-4861 | **Mail:** Kaiser Permanente  PO Box 30766  Salt Lake City, UT 84130 | | |
| **Today’s Date** |  |
| First Level / Second Level | First Level  Second Level |
| Pre-Pay Review |  |
| Member's Name |  |
| Member's Consumer number |  |
| Claim Number(s) |  |
| Provider Name & Address |  |
| Contact Name, Phone Number & Fax Number |  |
| **Reason for Reconsideration** |  |