**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:

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| --- | --- |
| **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 |

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| **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** |  |