KAISER PERMANENTE®

PROVIDER RECONSIDERATION REQUEST FORM

ONLY FOR DENIALS RELATED TO AUTHORIZATION AND MEDICAL NECESSITY

**Notes a required field to avoid rejection of your request.

Submission Date	**Appellant Phone#
**Appellant Contact Name	**Appellant Fax# (Preferred method of communication)

**Appellant Business Name and Address	**City	**State	**Zip

PATIENT INFORMATION is required

Patient Name	
Date(s) of Service	Kaiser Permanente of WA ID Number
Kaiser Permanente Claim number(s)	1 Total Billed Amount in Question

****All requests must include a detailed reconsideration letter stating the extenuating circumstances that prevented your facility from obtaining a prior authorization.**

****Missing or incomplete information will result in rejection of your reconsideration request.**

PHYSICIAN: OFFICE/ ASC/DME/OTHER INPATIENT /OBSERVATION

Qualifying circumstances for a reconsideration are patient presented with other insurance, the service was urgent, the patient was not responsive or had cognitive impairment, the patient was non-English speaking, or a child without a parent.

****Please submit documentation to support your reason for reconsideration. This could be registration/patient demographics, applicable medical records, documentation showing a translator was not obtained timely or was not available, and/or documentation showing the child presented without a parent.**

HOSPITAL: INPATIENT /OBSERVATION REQUIRED DOCUMENTS FOR REVIEW

- Registration and verification of insurance (if we were not notified of the stay)
- Procedures or operative reports
- ER notes
- Daily MD progress notes
- History & physical
- Discharge Summary

Submit reconsiderations through our Portal https:// wa-provider.kaiserpermanentEDrg/ by fax or mail.

Kaiser Foundation Health Plan of Washington
Provider Reconsiderations
Fax: 844-660-0747

Attn: Provider Reconsideration ACN-16
PO Box30766
Salt Lake City, UT 84130-0766