HCHCP RECONSIDERATION FAX FORM

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

1. Member Subscriber ID (10 Digit ID):	2. Member Last Name:	3. Member First Name:
4. Case Reference Number:		
5. Primary Procedure CPT Code(s):	6. Primary Procedure CPT Code(s) Description:	
Please note- clinical information may be attached to form request, but 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 Information (Direct name and extension):		

Last Updated 7/2021