Re-Review Request Form

This form is for providers to use for members of Coordinated Care of Washington, Inc. or Ambetter from Coordinated Care Corporation.

Purpose of this form: If you received a medical necessity denial and there is additional clinical information that may change the outcome of our decision, please submit this form and associated clinical to the fax numbers on page 2.

Note: All Fields Required

Date: Auth #: Admit or Service Start Date:

Member Name: DOB: Date Range of Denial:

Service Requested:

Please choose one of the following criteria to qualify for a re-review of the previously denied service/admission (must chose at least one):

Do not use this form to request Administrative Days (please use the Administrative Day Request Form) or to request Change in Condition for member on Administrative Days (please use the Change in Condition Form).

	Reason for Re-Review Request	Filing Timeline
☐	Did not submit Medical Records timely and would like to submit them and have the Health Plan re-review authorization.	Inpatient Concurrent Review within 5 days of denial Pre-Service within 45 days of denial
☐	Medical Records were submitted timely, however, Provider believes denial was based on incomplete clinical information.(for example: records were missing PT/OT notes, or Behavioral Assessment)	Inpatient Concurrent Review within 10 days of denial Pre-Service within 45 days of denial
☐	At time of review by Health Plan there were pending diagnostics, procedures, or laboratory results, preventing full clinical picture (for example: blood cultures returned positive after denial issued.)	Inpatient Concurrent Review within 10 days of denial Pre-Service within 45 days of denial
☐	Currently admitted Member in denied status with a new condition/diagnosis that meets inpatient criteria. (for example member fell and now has broken hip) *For members on Administrative Days please submit a change in condition form*	Inpatient Concurrent Review within 5 days of denial

Provide reason for incomplete clinical or member's change in condition:

Please submit the complete Medical Record including the previously missing records or new clinical information necessary for complete clinical review along with this fax form to the following numbers

Denial Type	Line of Business	Fax Number
Biopharmacy	Medicaid/Ambetter	855-678-6980
Behavioral Health	Medicaid/Ambetter	833-286-1086
Inpatient Physical Health	Medicaid Ambetter	844-965-0317 855-218-0587
Pre-Service Physical Health	Medicaid Ambetter	877-212-6669 855-219-0592