



REQUEST FOR RECONSIDERATION REVIEW

If you do not agree with the findings contained within the report and wish to request a Reconsideration Review, please complete this form and submit along with supporting documentation. Use additional pages when necessary.

ALL fields MUST be completed to be eligible for Reconsideration Review.

Provider Number:	APD Area:	APD Region:
Provider/Agency Name:		
Provider Street Address/ City / State / Zip:		
Provider Location – Site Reviewed (If Applicable):		
Provider Discovery Review Date:		
Qlarant Reviewer Name:		
Name of Service (s) and Billing Discrepancy Standard(s) for which Reconsideration is being requested:		
Documentation attached to Support Reconsideration Request:		
Name of Person to Contact / Phone Number:		

Tampa Office
14025 Riveredge Dr.
Suite 150
Tampa, FL 33637
(866) 254-2075
(888) 877-5993 Fax

Tallahassee Office
2039 Centre Pointe Blvd.
Suite 202
Tallahassee, FL 32308
(850) 671-5044
(888) 877-5993 Fax

Toll Free Contact
Customer Service
1-866-254-2075