Florida Statewide Quality Assurance Program

delmarva foundation

RECONSIDERATION REQUEST

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:
Provider/Agency Name:	
Provider Street Address/ City / State / Zip:	
Provider Location – Site Reviewed (If Applicable):	
Provider Discovery Review Date:	
Delmarva 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:	

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1-866-254-2075