



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 Region:	PDR Review ID:
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:		