MAP-703 (rev. 3/2014)

Cabinet for Health and Family Services
Department for Medicaid Services
Request for Reconsideration
Ancillary Therapy Billing

A nursing facility that disagrees with the Carewise Health, Inc. denial for ancillary therapy billing may request reconsideration. All facility requests for reconsideration shall be made in writing, using this form, within seven (7) days of the notification date that an ancillary therapy modality had not been approved by the review agency.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Facility Name: ____

Medicaid Provider Number: ____________________________________

Address: ____

Telephone Number: ____

Resident's Name: ____

Medicaid Number: ____

Effective Date of the Denial: __________________________________

IN ORDER TO ESTABLISH A BASIS FOR RECONSIDERATION:

1) Enclose a copy of the resident's Ancillary Services Determination form.
2) Write a brief description of your disagreement with the denial. (Attach rationale to this form.)
3) Attach documentation establishing that the resident's needs, at the time of the denial, justify ancillary therapy billing.

I signify by my signature that these statements are correct and factual to the best of my knowledge.

Signature: ____________________________________ Date: ____/____/____

Title: ____

Mail to: Carewise Health, Inc.
9200 Shelbyville Road, Suite 800
Louisville, KY 40222-8560
Attn: Field Review/Ancillary Reconsideration
Department for Medicaid Services