Bill Reconsideration Form

SUBMIT DIRECTLY TO THE APPLICABLE CLIENT

This form will assist you in requesting a reconsideration from the client. Please be advised that all confidential patient information should be transmitted securely and in accordance with applicable federal and state privacy laws.

Request Date: ______________________________

Please select network:

- ☐ Aetna Signature Administrators (ASA)
- ☐ Aetna Workers' Compensation Access (AWCA)
- ☐ Cofinity Auto Network (PIP)

Provider Name		
Provider Service Location (Street, Suite, City, State, ZIP Code)		
Patient Account Number	Tax Identification Number	PIN
Contact Name	Phone Number	E-mail Address

Employee Name		
Employee Address (Street, Apt No., City, State, ZIP Code)		
Social Security Number / Alt Member ID	Date of Birth	Employer Name

Client Name		
Date of Service	Client Bill ID / Claim Number	
Charge $ ____________	**Payment** $ ____________	**Requested** $ ____________
Reasons for reconsideration (detailed statement):		

Documents attached: ☐ No ☐ Yes, Description: ______________________________