CULINARY PROVIDER RECONSIDERATIONS FORM

DATE: ______________________________

CLAIM #: ______________________________

PATIENT NAME: ______________________________

DATE OF SERVICE: ______________________________

CPT/HCPCS CODE(S) REQUIRING REVIEW: ____________________

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PROVIDER TIN: ______________________________

PROVIDER NAME: ______________________________

CONTACT PERSON: ______________________________

PHONE NUMBER: ______________________________

REASON FOR REQUEST (brief description of the issue[s])**:**

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ATTACHMENTS: Check all that apply

- ☐ Copy of Claim
- ☐ CCI guidelines
- ☐ Operative Report
- ☐ Contract Language
- ☐ Medical Records
- ☐ Other ______________________________

Culinary Health Fund
P.O. Box 211471
Eagan, MN 55121