Provider Reconsideration Request - Referrals and Medical Necessity Form

Only For Denials Related to Authorization and Medical Necessity

All requests must include a detailed reconsideration letter and this filing form.

Missing or incomplete information will result in rejection of your reconsideration request (You will be notified when this happens).

Note: Attachments cannot exceed a total of 20 pages. Larger documents must be mailed or faxed to:

Kaiser Foundation Health Plan of Washington
Attn: Provider Reconsideration ACN-2
PO Box 30766
Salt Lake City, UT 84130-0766
FAX: 844-660-0747

*Required fields

Download form

SUBMISSION DATE *

Provider Info

APPELLANT CONTACT NAME

APPELLANT BUSINESS NAME

APPELLANT PHONE

APPELLANT EMAIL

APPELLANT FAX

TAX ID

Provider Address

APPELLANT STREET ADDRESS LINE 1 *

APPELLANT STREET ADDRESS LINE 2

CITY *

STATE *

Washington

ZIPCODE *

Patient Info

PATIENT NAME*

KAISER PERMANENTE OF WA ID NUMBER*

DATE(S) OF SERVICE*

TOTAL BILLED AMOUNT IN QUESTION

CLAIM NUMBER(S)*

DETAILED RECONSIDERATION LETTER NOTING REASON *

Choose File No file chosen

**All requests must include a detailed reconsideration letter stating the extenuating circumstances that prevented your facility from obtaining a prior authorization.

**Missing or incomplete information will result in rejection of your reconsideration request.

Physician: Office/ASC/DME/Other Inpatient/Observation

Qualifying circumstances for a reconsideration are patient presented with other insurance, the service was urgent, the patient was not responsive or had cognitive impairment, the patient was non-English speaking, or a child without a parent.

**Please submit documentation to support your reason for reconsideration. This could be registration/patient demographics, applicable medical records, documentation showing a translator was not obtained timely or was not available, and/or documentation showing the child presented without a parent.

Hospital: Inpatient/Observation Required Documents for Review:

REGISTRATION AND VERIFICATION OF INSURANCE (IF WE WERE NOT NOTIFIED OF THE STAY)

Choose File No file chosen

PROCEDURES OR OPERATIVE REPORTS

Choose File No file chosen

ER NOTE

Choose File No file chosen

DAILY MD PROGRESS NOTES

Choose File No file chosen

HISTORY & PHYSICAL

Choose File No file chosen

DISCHARGE SUMMARY

Choose File No file chosen

CONSULTATIONS

Choose File No file chosen

OTHER ATTACHMENTS

Choose File No file chosen

Submit

Contact a Department

Contact Us

Other KP region contacts
Other KP region provider sites

Provider Assistance Unit

For status updates or issues with claims and referrals

1-888-767-4670

Medical offices

Medical center hours and locations
Holiday closures and hours