Alfa Health Plans
Phone 833-468-4220
alfahealth.net

Request for Reconsideration of Rate

Primary Member Name: _____ ID Number: _____

What you need to know:

- When processing Reconsideration of Rate, Alfa Health Plans Enrollment Department will review **all claims experience (if applicable) along with any current health conditions, medications, and/or treatment** to determine if you are eligible for a rate reduction based on our current underwriting standards. If the factors in your original underwriting decision are resolved in your favor, it may be possible that current health conditions, medication, and/or treatment will prevent a rate reduction to be allowed for your coverage at this time.
- Any information submitted may result in the Alfa Health Plans Enrollment Department requesting additional medical information.
- If you and/or your dependents were originally rated for height and weight, blood pressure reading, blood pressure medication, cholesterol reading or cholesterol medication, glucose reading or Hemoglobin A1C Reading, we may require current readings in the last 12 months taken by a healthcare professional to review your rate.
- If your plan is a family plan, we will require the form be completed with everyone's information listed on the contract to reconsider your family rate. If it is not completed in entirety, the form will be returned.

Have you or any dependents on the plan had any disease, disorder, medical condition, symptom, or treatment/surgery since the submission of your original application?

_____
_____
_____
_____

Please provide any additional information regarding conditions you were originally rated for that you would like to have reconsidered:

_____
_____
_____
_____

List all medications that are currently being taken or have been taken in the last two (2) years by you and any dependents on this contract:

Name:	Name of Drug:	Illness:	Date Started:	Date Stopped:

List current height and weight for you and any dependents on this contract.

Name:	Height:	Weight:	Date Weighed:

You may also attach pertinent documents including medical records, pharmacy records, and any other information you would like considered during the reconsideration process.

Please send this form along with any documentation to the address below:

Email: underwritingforms@fbhpservices.com | Fax: 931-560-4293

I understand the information in this Request for Reconsideration and any information obtained with this authorization will be used by Alfa Farm Bureau Health Plans to determine the outcome of this reconsideration. I declare the foregoing statements provided by me in this request in its entirety are true, correct, and complete for myself, my spouse, and all dependent children.

Member Signature: _____ Date: _____

Spouse Signature: _____ Date: _____