Request for Reconsideration of Tobacco Rate

ALFA Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 833-468-4220
Billing Fax: 931-560-4278
Billingforms@fbhp.com

General Information

Please send this form along with any documentation to the address listed in the upper right hand corner.

Subscriber Information

First Name	MI	Last Name

Health Plan Subscriber ID Number

Tobacco Use Information

- Answer each of the following questions completely and accurately for you, your spouse and all dependent children on the contract.
- **This request will not be processed without the requested information.**

☐ Yes ☐ No — Have you, your spouse, or any dependent children on this contract ever used tobacco in any form (i.e. cigarettes, cigars, pipe, chewing tobacco or snuff)? If Yes, complete the following:

Name of Subscriber/Dependent	Relationship to Subscriber	Last Date of Tobacco Use

Use the space below to provide any additional information for reconsideration.

Authorization

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

Subscriber Signature	Today's Date	Spouse Signature	Today's Date

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.