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

Request for Reconsideration of Benefit Exclusion

Member Name:_____ **ID Number:**_____

I wish to submit the following request for the Alfa Health Plans Underwriting Department to reconsider a Benefit Exclusion. **Claims experience may be used in the reconsideration process.**

Name of Person with Benefit Exclusion:
Description of Benefit Exclusion:

Answer each of the following questions completely and accurately. **We will not be able to process this request without the requested information.**

In the last two (2) years, has the person with the Benefit Exclusion had symptoms, pain, or received treatment related to the condition excluded? Circle: YES or NO. If "YES," please explain in detail:

_____

_____

_____

When was the last date the person with the Benefit Exclusion had symptoms, pain, or received treatment related to the condition excluded? Please be specific (month, year).

_____

_____

_____

List all medications that the person with the Benefit Exclusion is currently taking or has been advised to take in the last two (2) years for the condition excluded by the Benefit Exclusion:

Name of Drug	Is medication currently being taken?	Date Started	Date Stopped

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

_____

_____

_____

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:

Email: underwritingforms@fbhp.com Fax: 931-560-4293

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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 this 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.

Member Signature:_____ Date: _____