Provider Reconsideration Request Form

Please submit all reconsideration requests within 30 days of the clinical or administrative claim decision or authorization decision.

Note: Please ensure all fields are completed and submit the appropriate documentation to avoid delays in processing.

Provider Information:

- **Provider Name:** _____
- **Provider Address:** _____
- **City, State, Zip Code:** _____
- **Provider NPI Number:** _____
- **Contact Person:** _____
- **Phone Number:** _____
- **Email Address:** _____

Claim Information:

- **Claim Number:** _____
- **Date of Service:** _____
- **Patient Name:** _____
- **Patient MassHealth ID Number:** _____
- **Authorization Number (if applicable):** _____

Reason for Reconsideration Request:
Please provide a detailed explanation of why you disagree with the decision and any new information that supports your request. Be as specific as possible.

Supporting Documentation:
Please check the documentation that is being submitted to support your reconsideration request:

- ☐ New information not submitted with the original request (please include narrative on office letterhead, clear photographs/radiographs, etc.)
- ☐ Denial of prior authorization (provide any new clinical or radiographic evidence)
- ☐ Denial due to extracted tooth (submit radiographs and clinical notes)
- ☐ Denial due to untimely filing
- ☐ Denial for service not billable (submit radiographs of the tooth/teeth and clinical notes)
- ☐ Denial due to patient not eligible (provide proof of eligibility from the member eligibility detail screen or list)
- ☐ Other (please describe): _____

Additional Documentation or Comments:
Please provide any additional details or documents that may support your reconsideration request.

Certification and Signature:
By signing below, I certify that the information provided in this reconsideration request is accurate and complete to the best of my knowledge. I understand that submitting false information may result in penalties or denial of the reconsideration request.

- **Provider Signature:** _____
- **Date of Submission:** _____

Please submit this completed form and all supporting documentation via:

- **Mail to:**
  MassHealth Dental Program
  c/o BeneCare Dental Plans
  P.O. Box 612
  Worcester, MA 01613
- **Email: Grievances@massdhp.com**

Reconsideration requests must be submitted within 30 days of the determination at issue.