

UHCIC PROVIDER RECONSIDERATION REQUEST FORM

DIRECTIONS: If you wish to file a 'Provider Reconsideration' on a claim, please fill out this form and fax it to 727-456-7877 or mail it, along with required documentation to:

Universal Health Care Insurance Company
Attn: Provider Reconsiderations
PO Box 1259
St. Petersburg, FL 33731

NOTE: Failure to complete **ALL** the data elements on this form **and/or** failure to submit the necessary documentation will result in your request for a dispute resolution being dismissed. Disputes must be submitted no later than 120 days after the payment date. This form is intended for use by Provider's not members.

Provider Name			
Provider Identification Number (UHCIC ID number or NPI)			
Patient Name			
Patient UHCIC ID number			
Full date range of service			
Specific date(s) of items in dispute			
UHCIC claim number			
Denied service and reason for dispute			
Requester's Name		Title	
Requester's e-mail address			
Requester's mailing address		City	State Zip Code
Requester's telephone number (include area code)			
Requester's signature		Date signed	

The following items are required to file a reconsideration:

- Letter explaining the reason for the reconsideration request with supporting documentation

- Copy of claim

- Copy of Explanation of Benefits (EOB)

- Proof of correct payment amount