

## Request for Reconsideration Ancillary Therapy Billing

A nursing facility that disagrees with the National Health Services' denial for ancillary therapy billing may request a reconsideration. All facility requests for reconsideration will be made in writing using this form, within seven (7) days of the date the facility is notified that a selected ancillary therapy modality has not been approved by the review agency.

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Facility Name: \_\_\_\_\_

Facility Medicaid Provider Number: \_\_\_\_\_

Facility Telephone Number: \_\_\_\_\_

Facility Address: \_\_\_\_\_

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Resident's Name: \_\_\_\_\_

Resident's Medicaid Number: \_\_\_\_\_

Effective Date of the Denial: \_\_\_\_\_

**IN ORDER TO ESTABLISH A BASIS FOR RECONSIDERATION:**

- 1) Enclose a copy of the resident Ancillary Services Nursing Facility Determination form.
- 2) Write a brief description of the basis for your disagreement with the denial. (Attach rationale to this form.)
- 3) Attach documentation establishing that the needs of the resident at the time of the denial justify ancillary therapy billing.

I signify by my signature that these statements are correct and factual to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: \_\_\_\_\_

Mail to:           Attn: Field Review Supervisor  
National Health Services  
9200 Shelbyville Road, Suite 700  
Louisville, KY 40222