HEALTH PLANS

Ohio Farm Bureau Health Plans
Phone 833-468-4280
ohiofarmbureauhealthplans.org

Request for Reconsideration of Declined Coverage

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

Your request must be made within thirty (30) days of the original decision to decline coverage.

Name of member who was declined: _____

Please provide detailed information for the reason(s) the member was declined:

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Please read carefully and note the following:

This information submitted may result in the Ohio Farm Bureau Health Plans Medical requesting additional medical information. Obtaining additional medical information and any expenses incurred for that information will be your responsibility.

Claims experience may be used in the reconsideration process. If the factors in your original declined coverage decision are resolved in your favor, please know that symptoms, treatments, and/or claims experience for other medical conditions discovered during this review may cause you to remain declined.

You may attach pertinent documents including medical records, pharmacy records, and any other information you would like us to consider during the reconsideration process.

Please send this form along with any documentation to:

Email: underwritingforms@fbhpservices.com | Fax: 931-560-4293

I understand that the information in this request for reconsideration and any information obtained with this authorization will be used by Ohio Farm Bureau 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: _____

Spouse Signature: _____ Date: _____