Humana
Healthy Horizons®
in Virginia

Reconsideration Request Form

Please return completed form by mail to:

Humana Healthy Horizons in Virginia
Attn: Reconsiderations
P.O. Box 14359
Lexington, KY 40512-4359

From: _____
Telephone: _____
Email: _____

Required information

Member name: _____ Member ID number: _____
Date(s) of service: _____ Remittance advice date: _____
Amount billed: _____ Amount paid: _____

Authorization number: _____
Claim number: _____

Pended claim: Yes ☐ No ☐

Denial reason: _____
Procedure codes billed: _____

Denial code: _____

To request reconsideration of a denied or reduced authorization or claim reimbursement within 60 calendar days of notice, please use the space below to provide the reason for dispute and any other necessary information, along with your attachments, to enable a thorough reconsideration.

Signature: _____ Date: _____

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Humana Healthy Horizons® in Virginia shall acknowledge in writing its receipt of a reconsideration request within 7 business days after the receipt of the request and render a final decision by providing a response to the provider within 30 calendar days from the date of the receipt of the request for reconsideration unless another time frame is agreed upon in writing by the provider and Humana Healthy Horizons in Virginia.