

PMMP Provider Pathways Reconsideration Request Form Physical/Occupational Medicine

Directions:

- 1) If you wish to file for a reconsideration of your status, please complete this form.
- 2) Email the completed form to PMMPpathwayR&A@highmark.com **by Dec. 1 of the current program year.** (IMPORTANT NOTE: Reconsideration requests received after Dec. 1 of the preceding program year will not be evaluated.)

Date: ____/____/____

Blue Shield ID Number: _____

Name of Person/Facility Requesting the Reconsideration: _____

Phone Number: _____ -- _____ -- _____

Address: _____

I am requesting a reconsideration of my status from a “Qualifying Provider” in the current program year to a “Non-qualifying Provider” in the upcoming program year. I disagree with the following (please check all that apply):

- Total Care Requests (Registration and Authorization)
- Total Care Authorization Approval Rate measurement
- Care Authorization Requests via Web measurement
- Average Visits per Member, Category 1 Conditions measurement
- Average Visits per Member, Category 2 Conditions measurement
- Average Physical Medicine (PM) Procedures, Modalities or Units per Visit

Why do you disagree with your status? Or what are your reasons for requesting reconsideration? (Attach additional pages if necessary.)

Signature: _____ **Date:** ____/____/____

