Provider Pathway Reconsideration Request Form
Radiation Oncology Bone/Brain Metastases

Directions:

1) If you wish to file for a reconsideration of your status, please complete this form
2) Email the completed form to RadOncPPReconsiderations@highmark.com

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 2015 to a "Non-qualifying Provider" in 2016. I disagree with the following (please check all that apply):

- ☐ Total Requests (Greater than 10)
- ☐ UM Denial Rate (Less than 2%)
- ☐ UM Partial Approval Rate (Less than 13%)

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

_____

_____

_____

Signature: _____ Date: _____/_____/_____

HIGHMARK.