



# Request for Reconsideration of Declined Coverage

**Member Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

I wish to submit the following request for the TRH Underwriting Department to reconsider the decision of declined coverage:

- Member Rejection
- Dependent (Child or Spouse) Rejection. Dependent Name: \_\_\_\_\_

Please provide detailed information for the reason you are requesting this reconsideration: \_\_\_\_\_

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**Please read carefully and note the following:**

- This information submitted may result in the TRH Medical Underwriting Department requesting additional medical information. Obtaining this information and any expenses incurred will be your responsibility.
- Claims experience from any previous TRH health plan or health coverage with BlueCross BlueShield of Tennessee 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 also attach pertinent documents including medical records, pharmacy records, and any other information you would like considered during the reconsideration process.

Please send this form along with any documentation to the below address:

TRH Health Plans  
 Attention: Underwriting Department  
 P.O. Box 313  
 Columbia, TN 38402-0313

I understand the information in this request for reconsideration and any information obtained with this authorization will be used by TRH 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:** \_\_\_\_\_ **Spouse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_