Hawaii Medicaid Fiscal Agent
1132 Bishop Street Ste. 800
Honolulu, HI 96813

Request for Reconsideration Form

Directions: Providers may use this form to request reconsideration of the allowed reimbursement amounts for specific services. Please limit your reconsideration requests to one claim per Form 240. All fields on Form 240 are required and must be completed. Upon completion, please send Form 240 and any attachments to Hawaii Medicaid Fiscal Agent, 1132 Bishop St., Suite 800 Honolulu, HI 96813. Upon receipt, we will conduct the preliminary research to verify that the claim was processed and paid in accordance with Medicaid policy. Claims processed incorrectly will be submitted for reprocessing. If we determine that the claim was processed correctly, we will forward the request for reconsideration to Med-QUEST (MQD) for review. MQD will make the final determination. A request for reconsideration of payment amount or adjudication must be made within sixty days from payment or adjudication date.

Date of Request:	Provider Name:	Contact Name:
Provider ID #:	Provider Phone #:	Provider Fax #:
Provider Address (Street Address, City, State and Zip Code):	Provider E-mail Address:	
Claim Reference Number:	HAWI ID #:	Date(s) of Service
List of Attached Documents:		
Reconsideration Justification:		

Date FA Completed Research: _____

Completed By:

_____

Forwarded to ☐ MQD

☐ Claims Resolution