Liberty Mutual and Helmsman Management- Workers Compensation

RECONSIDERATION REQUEST FORM – Please attach a copy of the EOB from Liberty Mutual Insurance or Helmsman Management Services

Patient's Name: _____

Claim Number: _____

Provider's Name: _____

Provider's Address: _____

Description of Item or Service in Question: _____

Date of Service in Question or Date of Item in Question: _____

I do not agree with the determination of my claim.

MY REASONS ARE: Document any additional information that you would like to be considered regarding the review of the medical bill in question.

Requester's Signature: _____Date Signed:_____

❑ I have evidence to submit. (Attach such evidence to this form.)

❑ I do not have evidence to submit.