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| **Department of Vermont Health Access** *Agency of Human Services*NOB 1 South, 280 State Drive phone: 802-879-5900Waterbury, VT 05671-1010 fax: 802-871-3090**dvha.vermont.gov**  |

**Request for Reconsideration by Special Investigations Unit (SIU)**

**Today’s Date:**

**SIU Case #:**

**Provider Name:**

**Provider Number:**

**Date of the Determination of Improper Payment Notice (mm/dd/yyyy) (please include a copy of the notice with this request):**

**Reason for Reconsideration (Include additional pages if necessary):**

**Additional Information SIU Should Consider:**

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| * **I have documentation to submit.**

Please attach the documentation to this form and attach a statement explaining your reasons for the reconsideration request.**Person Requesting Reconsideration**  | * **I do not have additional documentation to submit.**
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|  | * **Provider**
 | * **Authorized Representative**
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| **Mailing Address:** |

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| **Signature of Provider or Authorized Representative** |
|  |
| **Print Name** |

**Please submit the request via secured fax (802) 871-3090 or SIU inbox at** ReportMedicaidFraud@vermont.gov