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| **Department of Vermont Health Access** *Agency of Human Services*  NOB 1 South, 280 State Drive phone: 802-879-5900  Waterbury, 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.** |
|  | * **Provider** | * **Authorized Representative** | |
| **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](mailto:ReportMedicaidFraud@vermont.gov)