Request for Claims Reconsideration Form

Today's Date:	**Health Plan Name: Heraya Health**
Provider Information	
Provider Name:	**Contact Name:**
NPI #:	**Contact Phone #:**
Member / Claim Information	
HRN#:	**Member Name:**
Date (s) of Service (MM/DD/YY):	
Claim Number (s):	
***Claims Reconsideration Type**	
Enter X in the box below to reflect the claims reconsideration type	
	Timely Filing
	Other
***Claims Reconsideration Explanation**	
Where to Send Information	

Mail: Heraya Health, 6600 SW 105th Avenue, Suite 115, Beaverton, OR 97008
Fax: 503-203-8522
For Questions call: 503-203-8333

Fax or mail the following information to Heraya:

- Request for Claims Reconsideration Form
- A copy of Heraya's Remittance Advice Denial
- Supporting documentation reflecting the new information