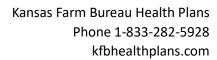


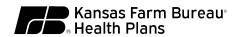


Request for Reconsideration of Rate

Member Name:		ID Num	ber:	
I wish to submit the Department to reco	<u> </u>	to Kansas Farm Bur coverage.	eau Health Plans Er	nrollment
What you need to	know:			
Department determine if the factors in that current allowed for y Claims exper the reconside Any informat Department If you and/or reading, block reading or He taken by a helical to the company of the	will review all current you are eligible for a your original undervi- health conditions, me four coverage at this to ience from any previous eration process. ition submitted may re- requesting additional your dependents we and pressure medications emoglobin A1C Readi ealthcare professionals a family plan, we will contract to reconsider	on of Rate, Kansas Far t health conditions, m rate reduction based writing decision are re edication, and/or trea- time. ous Kansas Farm Bure esult in the Kansas Fa I medical information ere originally rated for on, cholesterol readin ing, we will require cu I to review your rate. Il require the form be er your family rate. If	nedications, and/or tron our current under esolved in your favor, atment will prevent a eau Health Plan cover made and weight, and weight, and weight, are completed with ever example to the ecompleted with ever on our constant and weight.	reatment to rwriting standards. If it may be possible rate reduction to be rage will be used in ans Enrollment blood pressure ication, glucose last 12 months
	=	being taken or havent children on this		e last two (2) years
Name:	Name of Drug:	Illness:	Date Started:	Date Stopped:
		1		

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List current height and weight for you, your spouse, and all dependent children on this contract.

	Height:	Weight:	Date Weighed:
	lauta an ulau had ann	. diaaaaa . diaawday waad	: diti
Have you or depend treatment within th	-	disease, disorder, med	ical condition, symptom, or
You may also attach	pertinent documents	including medical recor	ds, pharmacy records, and an
other information yo	ou would like consider	ed during the reconside	ration process.
Please send this forr	m along with any docu	mentation to the below	address:
		was Duwsau Haalth Dlags	
		rm Bureau Health Plans Enrollment Department	
	Attention:	Enrollment Department PO Box 313	
	Attention: Colum	Enrollment Department PO Box 313 Ibia, TN 38402-0313	
	Attention: Colum Email: <u>underwrit</u>	Enrollment Department PO Box 313 abia, TN 38402-0313 aingforms@fbhpservices	.com
	Attention: Colum Email: <u>underwrit</u>	Enrollment Department PO Box 313 Ibia, TN 38402-0313	.com
	Attention: Colum Email: <u>underwrit</u> Fa ormation in this Reque	Enrollment Department PO Box 313 bia, TN 38402-0313 ingforms@fbhpservices x: 931-560-4293 est for Reconsideration a	and any information obtained
with this authorizati	Attention: Colum Email: <u>underwrit</u> Fa ormation in this Reque on will be used by Kar	Enrollment Department PO Box 313 bia, TN 38402-0313 bingforms@fbhpservices x: 931-560-4293 est for Reconsideration ansas Farm Bureau Health	and any information obtained n Plans to determine the
with this authorization outcome of this reco	Attention: Colum Email: <u>underwrit</u> Fa ormation in this Reque on will be used by Kar onsideration. I declare	Enrollment Department PO Box 313 bia, TN 38402-0313 bingforms@fbhpservices x: 931-560-4293 est for Reconsideration ansas Farm Bureau Health the foregoing statemen	and any information obtained n Plans to determine the nts provided by me in this
with this authorization outcome of this reco request in its entiret	Attention: Colum Email: <u>underwrit</u> Fa ormation in this Reque on will be used by Kar onsideration. I declare	Enrollment Department PO Box 313 bia, TN 38402-0313 bingforms@fbhpservices x: 931-560-4293 est for Reconsideration ansas Farm Bureau Health the foregoing statemen	and any information obtained n Plans to determine the nts provided by me in this
with this authorization outcome of this reco request in its entiret	Attention: Colum Email: <u>underwrit</u> Fa ormation in this Reque on will be used by Kar onsideration. I declare	Enrollment Department PO Box 313 bia, TN 38402-0313 bingforms@fbhpservices x: 931-560-4293 est for Reconsideration ansas Farm Bureau Health the foregoing statemen	and any information obtained n Plans to determine the nts provided by me in this
with this authorization outcome of this reco request in its entiret children.	Attention: Colum Email: <u>underwrit</u> Fa ormation in this Reque on will be used by Kar onsideration. I declare	Enrollment Department PO Box 313 abia, TN 38402-0313 aingforms@fbhpservices x: 931-560-4293 est for Reconsideration ansas Farm Bureau Health the foregoing statemen d complete for myself, re	and any information obtained n Plans to determine the nts provided by me in this
with this authorization outcome of this reconnection request in its entiret children. Member Signature:	Attention: Colum Email: underwrit Fa ormation in this Reque on will be used by Kar onsideration. I declare by are true, correct, an	Enrollment Department PO Box 313 bia, TN 38402-0313 bingforms@fbhpservices x: 931-560-4293 est for Reconsideration ansas Farm Bureau Health the foregoing statement d complete for myself, re	and any information obtained n Plans to determine the

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