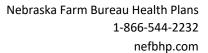


Request for Reconsideration of Rate

Member Name: _____ ID Number: _____

| | ne following request consider my rate fo | | Bureau Health Plar | ns Enrollment |
|--|--|--|--|---|
| What you need to | know: | | | |
| Department of determine if the factors in that current leadlowed for your claims experise the reconside Any informate Department of the partment of the taken by a headling or | ryour original underwhealth conditions, may our coverage at this rience from any previous eration process. The consubmitted may represent the process of pressure medication and pressure medications at family plan, we will contract to reconsiderm. | t health conditions, no rate reduction based writing decision are reduction are redication, and/or treatime. The sult in the Nebraska I medical information are originally rated for on, cholesterol reading, we will require cult to review your rate. If I require the form beer your family rate. If the being taken or have | nedications, and/or and on our current und esolved in your favoratment will prevent ureau Health Plan conformations. Farm Bureau Health on the properties of the completed with every not completed in error to the completed in the completed in the completed in the complete to the completed in the complete to | treatment to erwriting standards. If r, it may be possible a rate reduction to be overage will be used in r Plans Enrollment blood pressure dication, glucose |
| Name: | Name of Drug: | Illness: | Date Started: | Date Stopped: |
| | | | | |
| | | | | |
| | | | | |

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

| Name: | Height: | Weight: | Date Weighed: |
|--------------------|---------------------------|---|-------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| <u> </u> | | | |
| Have you or done | ndonts on plan had any | disassa disardar mad | ical condition, symptom, or |
| treatment within | • | aisease, aisoraer, mea | ical condition, symptom, or |
| treatment within | the last 7 years: | | |
| | | | |
| | | | • |
| Vou may also attac | ch nortinant documents i | ncluding modical rocor | ds, pharmacy records, and any |
| • | you would like considere | _ | • • • • |
| other information | you would like considere | tu during the reconside | ration process. |
| | | | |
| Please s | send this form along with | n any documentation to | the below address: |
| | Nobraska Fa | ırm Bureau Health Plans | |
| | | Enrollment Department | |
| | | PO Box 313 | |
| | | oia, TN 38402-0313 | |
| | | ngforms@fbhpservices :: 931-560-4304 | .com |
| | FdX | : 931-300-4304 | |
| I understand the i | nformation in this Reque | est for Reconsideration | and any information |
| obtained with this | authorization will be us | ed by Nebraska Farm B | ureau Health Plans to |
| determine the out | come of this reconsider | ation. I declare the fore | going statements provided by |
| | | | or myself, my spouse, and all |
| dependent childre | en. | • | |
| Member Signature | <u>:</u> | | |
| | | | |
| | | | |
| Date: | | | |

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