

**YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED.
SIGNATURE MUST BE COMPLETE AND LEGIBLE. THIS FORM MUST BE DATED.**

A. Provider Information	1. Provider Name:		2. TIN/NPI:	
	3. Provider Group (if applicable):			
	4. Contact Name:		5. Title:	
	6. Contact Address:			
	7. Phone:	8. Fax:	9. Email:	
B. Patient Information	1. Patient Name:		2. Ins. ID:	
	3. Did you attach a copy of (check the appropriate response):			
	a. Explanation of Benefits/Explanation of Payment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
	b. The Consent to Representation in Appeals of Utilization Management Determinations and Appropriate Consent Form? (Consent form is required for review of medical records if the matter goes to arbitration.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
C. Claim Information	1. Claim Number (if known):		2. Date of Service:	
	3. Authorization Number:			
	4. Claim filing method (check only one):			
	a. <input type="checkbox"/> electronic (submit a copy of the electronic acceptance report from our clearinghouse or us)			
	b. <input type="checkbox"/> facsimile (submit a copy of the fax transmittal)			
	c. <input type="checkbox"/> paper claim by mail or courier service (submit a copy of the delivery confirmation evidence)			
5. Check the reason(s) why you are filing this appeal (check all that apply and be specific about billing codes and reason for dispute):				
a. <input type="checkbox"/> Action has not been taken on this claim				
b. <input type="checkbox"/> Dispute of a denied claim → provide date of denial : _____				
c. <input type="checkbox"/> Claim was paid but not in a timely manner (provide more information):				
<input type="checkbox"/> Yes <input type="checkbox"/> No Additional information was requested? If yes, date: _____				
<input type="checkbox"/> Yes <input type="checkbox"/> No Additional information provided? If yes, date: _____				
<input type="checkbox"/> Yes <input type="checkbox"/> No Prompt Payment Interest paid correctly?				
d. <input type="checkbox"/> Claim was paid, but the amount paid is in dispute				
e. <input type="checkbox"/> Codes in dispute _____/_____/_____/_____/_____/_____/_____/_____				
f. <input type="checkbox"/> Dispute of an overpayment or the amount of overpayment (Attach a copy of overpayment request)				
D. Reason for Appeal (Required)				

Provider Name: _____

Contact Number: _____

Member Name : _____

DOS: _____

You may provide additional information in an attachment to explain why you are disputing our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Explanation(s) of Payment.
- A statement specifying the line items that you are appealing.
- Information we previously requested that you have not yet submitted, if available.
- Itemization of the provider contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract.
- Pertinent correspondence between you and us on this matter.
- A description of pertinent communications between you and us on this matter that were not in writing.
- Other documents you may believe support your position in this dispute (this may include medical records).

Attachments: ☐ Yes

☐ No

Signature: _____ Date: _____

Important to Note

In order to ensure your Appeal is eligible to meet processing requirements, please make sure of the following:

- The Appeal Form must be sent to the address posted on our website;
- The Appeal Form must have a complete signature (first and last name);
- The Appeal Form must be dated;
- There is a signed and dated Consent to Appeal Form and/or and Authorization to Release Medical Records.