Provider Appeal Form

Member ID* ______________________ **Member Name** ______________________

Date of Service ______________________ **Claim#** ______________________

Provider Name ______________________ **Appeal Submission Date** ______________________

Provider's Office Contact Name ______________________ **Provider Telephone#** ______________________

To avoid delays in processing provider appeals, please note:

- Incomplete appeal submissions will be returned unprocessed.
- A separate Provider Appeal Form is required for each claim appeal (i.e., one form per claim).
- Filing limit of the prevailing network applies.
- Include supporting documentation.

Appeal Type **Check one box, and/or provide comment below, to reflect purpose of appeal submission.**	**Required Documentation** **All bulleted items must be supplied from the row you check, along with the Provider Appeal Form and supporting documentation.**
☐ **No Surprises Act Open Negotiation Appeal** For Out-of-Network Provider Only	○ Open Negotiation Notice-OMB Control No. 1210-0169 ○ Copy of EOP ○ Supporting Documentation
☐ **Filing Limit**—appeal request for a claim or appeal whose original reason for denial was untimely filing.	○ 1500/UB claim form ○ Copy of EOP ○ Supporting documentation
☐ **Pre-certification/notification or prior-authorization denials**—appeal request for a claim whose original reason for denial was failure to notify or pre-authorize services.	○ Copy of EOP ○ Supporting documentation
☐ Provider requesting **Retraction of Overpayment** (i.e., not your patient; service not performed; etc.)	○ Copy of EOP ○ Along with the required documentation, supply additional information in the Comments section below.
☐ **Duplicate Claim**—appeal request for a claim whose original reason for denial was duplicate denial.	○ 1500/ UB claim form ○ Supporting documentation
☐ Response to a claim previously denied for **request for additional information**	○ Copy of EOP ○ Supporting documentation
☐ Submission of a **Corrected Claim**	○ Copy of EOP ○ Corrected 1500/UB claim form
☐ Response to a claim previously denied on a remittance for **Other Insurance Primary, Coordination of Benefits (COB), Motor Vehicle Accident (MVA), or Worker's Compensation (WC)**	○ Copy of EOP ○ Supporting documentation
☐ Request for reconsideration of a claim or appeals paid or denied incorrectly as a result of **contract rate, payment policy or clinical policy**	○ Copy of EOP ○ Supporting documentation which would include detail of the inquiry

Comments

Mail this form to:

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