

\*Today's Date (MM/DD/YY):

**PROVIDER INFORMATION**

*Provider Name	*Contact Name
*NPI	*Contact Phone Number
Contact Email	Contact Fax Number
*Contact Address	

**MEMBER/CLAIM INFORMATION**

*Member Name	*Claim Number
*Member ID (including prefix)	*Denial Code(s)
*Date(s) of Service (MM/DD/YY)	

**TYPE OF APPEAL\***

(CHECK ONE OF THE FOLLOWING REASONS FOR DENIAL OR CLAIMED UNDERPAYMENT, AND ATTACH ALL SUPPORTING DOCUMENTATION, INCLUDING ANY NECESSARY MEMBER AUTHORIZATION)

<input type="checkbox"/>	<b>Contract Term(s):</b> Original claim was not paid or processed in accordance with contract terms.
<input type="checkbox"/>	<b>Coordination of Benefits:</b> Original claim denied or closed pending receipt of additional information from another insurer or other reason related to COB.
<input type="checkbox"/>	<b>Corrected Claim:</b> Previously processed claim was denied for a defect and/or error and requires a correction. Please specify the correction to be made: _____
<input type="checkbox"/>	<b>Duplicate Claim:</b> Original claim denied as duplicate to a previously finalized claim.
<input type="checkbox"/>	<b>Timely Filing:</b> Original claim denied for untimely filing (and proof of timely filing is attached).
<input type="checkbox"/>	<b>Precertification/notification or Prior-Authorization:</b> Original claim denied or Provider received reduced payment for failure to notify or pre-authorize services or exceeding authorized limits (and proof of valid notification/authorization is attached).
<input type="checkbox"/>	<b>Medical Necessity:</b> Original claim denied as a result of medical necessity/utilization review decision.
<input type="checkbox"/>	<b>Referral Denial:</b> Original claim denied as invalid or missing a required referral.
<input type="checkbox"/>	<b>Request for Additional Information:</b> Original claim denied due to missing or incomplete information (and missing information or identification of such information in previously-submitted records is attached).
<input type="checkbox"/>	<b>Other Type of Denial/Claimed Underpayment:</b>

**Brief Explanation:**

**FOR PROVIDER USE ONLY**

**INCOMPLETE OR DISALLOWED SUBMISSIONS WILL BE RETURNED**

**NOTHING IN THIS FORM CREATES A RIGHT TO APPEAL WHERE NONE EXISTS UNDER AN APPLICABLE AGREEMENT OR LAW**