

PROVIDER APPEAL FORM

Completion of this form is mandatory to submit a request for an appeal for a claim or an authorization determination. To support your request, include with this form the supporting documentation and description of the appeal reason.

TYPE OF APPEAL

CLAIM APPEAL ☐	AUTHORIZATION APPEAL ☐	PROVIDER ENROLLMENT ☐
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TODAY'S DATE:	ALIEN/SUBJECT ID #:	TYPE OF CARE:
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ALIEN/SUBJECT FIRST NAME:	ALIEN/SUBJECT LAST NAME:	ALIEN/SUBJECT DATE OF BIRTH:
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PROVIDER NAME:	TIN:	PROVIDER GROUP (if applicable):
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CONTACT NAME AND TITLE:	
CONTACT ADDRESS:	
CONTACT PHONE NUMBER:	CONTACT EMAIL ADDRESS:

REASON FOR APPEAL		
CLAIM DENIED IN ERROR ☐	AUTHORIZATION ISSUE ☐	ENROLLMENT DETERMINATION DISPUTE ☐
MISSING AUTHORIZATION IDENTIFIED ☐	INCORRECT PAYMENT AMOUNT ☐	CLAIM PROCESSED INCORRECTLY ☐
OTHER (EXPLAIN): ☐		

CLAIM APPEALS INFORMATION		
Claim Number/TCN:	DATE OF SERVICE:	CLAIM DENIAL DATE:

AUTHORIZATION APPEALS INFORMATION	
AUTHORIZATION NUMBER:	

PROVIDER ENROLLMENT APPEALS INFORMATION	
APPLICATION ID:	

SUPPORTING DOCUMENTATION		
REMITTANCE ADVICE (RA) ☐	EXPLANATION OF BENEFITS (EOB) ☐	AUTHORIZATION DOCUMENT ☐
ENROLLMENT DOCUMENTATION ☐	MEDICAL DOCUMENTATION ☐	COVER LETTER ☐
OTHER SUPPORTING DOCUMENTS ☐		