CLAIM RECONSIDERATION-APPEAL REQUEST FORM

This form is for Standard Claims Reconsideration-Appeals only.

REQUEST TYPE	☐ Reconsideration ☐ Initial Appeal (Level 1)	☐ Second Level Appeal ☐ Other (not listed)

DO NOT USE FOR SUBMITTING MEDICAL RECORDS RELATED TO MEDICAL NECESSITY OR PRIOR AUTHORIZATION REQUIREMENTS

DEMOGRAPHIC INFORMATION			
Authorization Number:			
Claim Number:		Date of Service(s):	
Member Name:		Date of Birth:	Member ID Number:
Provider or Facility:			
NPI:	TIN:		
Primary Contact:	Phone:	Fax (required):	Email (required):
Second Contact:	Phone:	Fax:	Email:

TYPE OF DISPUTE:

☐ Contract Rate, Payment Policy, etc....	☐ Global, Bundled, Unbundled codes
☐ Proof of Eligibility	☐ Duplicate/Corrected claim incorrect denial
☐ Proof of Timely Filing: clearing house report, certified receipt signature, other-insurance denial	☐ Coordination of benefits information: Primary EOP/EOB
☐ Response to request for additional information: ER chart notes, Medical Records, Itemization, Invoice, etc....	
☐ Other, please explain:	

Additional Details: