



# ARC APPEAL REQUEST FORM

*This form is for Authorization Related Claims Appeals only.*

<b>REQUEST TYPE</b>	<input type="checkbox"/> Late Notification	<input type="checkbox"/> Services Exceed Authorization
	<input type="checkbox"/> Lack of Supporting Documentation (including preliminary authorizations)	<input type="checkbox"/> Other reason not listed

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 SUPPORTING DOCUMENTATION SUBMITTED:

<input type="checkbox"/> Proof of prior authorization (Must be a letter from IntegraNet or approval letter from Amerigroup)
<input type="checkbox"/> Discharge Summary, Medical Records, Clinical Documentation previously requested
<input type="checkbox"/> Other, please explain below:

### Additional Details:

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