

Provider Appeal Form

Please complete the following information and return this form with supporting documentation to the applicable address listed on the corresponding appeal instructions. Send only one appeal form per claim. Appeals must be submitted within one year from the date on the remittance advice. **Appeal Type and Sub Category must be checked to ensure proper routing.**

Date

Clinical Appeal Type (check one)

<input type="checkbox"/> Utilization Management (see below)	<input type="checkbox"/> Adverse Determination (Medical Necessity or Experimental/ Investigational)	<input type="checkbox"/> Coding and Payment Rule
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If a Utilization Management Appeal, complete the following:

Type: <input type="checkbox"/> Authorization <input type="checkbox"/> Precertification	Authorization or Precertification Number 2
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Administrative Appeal Type (check one)

<input type="checkbox"/> Claim Allowance	<input checked="" type="checkbox"/> Coordination of Benefits	<input type="checkbox"/> Provider Contract Issue	<input type="checkbox"/> Timely Filing	<input type="checkbox"/> Other	<input type="checkbox"/>
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If Administrative Appeal (Reconsideration Reference # Must Be Listed)

Reconsideration Reference # ciao questa prova
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1. Provider Information

Provider Name Prova 1	NPI # 5445	Florida Blue # 5989
Street Address Via degli astri 500	City Maputo	State MOZ Zip001400
Tel. #	Fax #	Contact Name

2. Patient Information

Patient Last Name Cazzo paziente	Patient First Name Puttana
Contract/ID # (alpha & #s) 3214894	Patient Date of Birth 02/5/1952

3. Claim Information

Claim Number 2184094940	
Billed Amount 250	Date(s) of Service (MM/DD/YYYY);(From) (To)
Procedure Code(s): 2	

4. Appeal Reason (Explain the reason for the appeal in the space below.)

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Supporting Documentation

The following supporting documentation must be attached to this form:

- Copy of the remittance advice or member's explanation of benefits. Indicate the code(s) or service(s) being appealed.
- Medical documentation related to the appeal (medical records, operative report, inpatient or emergency room face sheet, etc.) See applicable instructions for your appeal type.
- Any additional documentation.