

PROVIDER CLAIM APPEAL FORM

Please use this form to appeal your claim. Use **only one** Provider Claim Appeal Form per request. Send **only one** fax per reconsideration request.

1: CLAIM INFORMATION

Today's Date _____ / _____ / _____

Original Claim # _____

Contact Person _____

Phone # _____

2: MEMBER INFORMATION (PAYOR ID: 22HLT)

Full Name _____

Date of Birth _____ / _____ / _____

Member ID # _____

3: CLAIM APPEAL DETAILS

Please select and complete one of the below options:

☐ **Claim Denied for No Authorization:**

☐ Claim denied for "no auth" but services do not require an authorization

☐ Services were authorized, see auth number: _____

☐ Specific services were not authorized, but were medically necessary - attach supporting documentation with medical records that support service provided

☐ **Correction to Previously Submitted Claim or Health Plan Payment Error:**

Describe below what is to be corrected from original claim submission or payment error (e.g., units, coding, rate, etc.)

4: CLAIM APPEAL DETAILS

Please attach the corrected claim form and provide substantiating documentation, if applicable.

☐ **Claim Denied for Other Reasons:**

- ☐ Member Not Eligible on DOS/COB information requested – attach proof
- ☐ Untimely filing – attach proof
- ☐ Records/Invoice Requested – attach records
- ☐ NCCI Edits (e.g.: BUND/CMPD) – attach records to substantiate procedure(s)
- ☐ Other – Briefly describe below, and attach supporting documents if available.

5: SUBMIT DOCUMENTATION

Please submit this completed form along with the required documentation via the PlanLink Provider Portal.

<https://PlanLink.ccpcares.org>

If you do not have access to the PlanLink Provider Portal, please submit via fax to:

[\(954\) 417-7187](tel:(954)417-7187)

Claim appeals faxed to the wrong number will not be accepted.