# PROVIDER CLAIM APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant Carelon Post Acute Solutions to re-evaluate its original decision.

- An appeal request must include claim numbers and supporting documentation (e.g. complete copy of the medical records and claim form).
- The appeal request must be received within 90 days of the date of denial listed on the EOP.
- Review of a claim does not guarantee a change in payment disposition.
- An acknowledgement letter will be sent to you within ten (10) calendar days upon receipt of the Appeal Form.

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**Provider Information:**

Provider Name: _____

Provider NPI #:_____

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**Claim Information:**

Member Name: _____Claim Number(s): _____

Member Group & ID #:_____ Date(s) of Service: _____

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**Reason for Appeal:**

- ☐ Timely Filing – Claims with DOS submitted beyond the allowed days as outlined within providers contractual agreement
- ☐ Pricing – Incorrect payment or application of benefits
- ☐ Eligibility – Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- ☐ Medical Policy – Appeal a denial for failure to obtain prior authorization (Supporting documentation required).
- ☐ Other – Provide a detailed description

**Description of Claim Appeal:**

_____

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**Supplemental Documentation Attached:**

☐ Remittance Advice ☐ Refund ☐ Medical Records ☐ Other (e.g. Timely filing Documentation)

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**Contact Information:**

Requester:_____ Phone #:_____ Date:_____

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Please submit completed form and attachments via secure and encrypted email to:

claimappeals@mynexuscare.com

# WAIVER OF LIABILITY STATEMENT

| Claim #: |
|---|

| Enrollee's Name: | Member ID: |
|---|---|
| Provider: | Dates of Service: |
| Health Plan: | |

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

| Signature: | Date: |
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