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.

Provider Information:

Provider Name: _____

Provider NPI #:_____

Claim Information:

Member Name: _____Claim Number(s): _____

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

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:

_____

_____

Supplemental Documentation Attached:

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

Contact Information:

Requester:_____ Phone #:_____ Date:_____

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

claimappeals@mynexuscare.com

Attachment B