fridayhealthplans.com
800-475-8466

Provider Appeal Form

Please complete the following information entirely and return this form with supporting documentation to the applicable address listed below. Send only one appeal per claim.

- Before filing an appeal, Please review and ensure filing an appeal is appropriate.
- If a claim has not been acted upon, i.e., not paid or formally denied, please verify claims status first.
- If the claim has been returned for insufficient or incorrect information to be corrected, please submit this action before submitting an appeal.
- Provider relevant supporting documentation, including but not limited to: copy of claim, explanation of payment, medical records, and previous related correspondence. If sufficient information in not included, an appeal review may be delayed on not conducted.

Date:	Type of Appeal: Claim ☐ Authorization ☐

Provider/Group/Facility Information

Provider/Group/Facility Name:		
Provider TIN/NPI Number:		
Contact Name:		
Phone Number:	**Fax Number:**	
Email Address:		
Address:	**Apt./Suite:**	
City:	**State:**	**Zip Code:**

Member Information

Last Name:	**First Name:**	
DOB:	**Member ID Number:**	
Address:	**Phone Number:**	

Claim Information

Provider	**Facility**	**Ancillary Health Care Professional (DME, lab, ect.)**	
Claim #:	**Authorization # (if applicable)**	**DOS:**	
Billed Amount:	**Paid Amount:**		

State reason for Appeal:

Submission Options: Fax, email, mail

Fax: 844-280-1794, *please do not fax more than 100 pages at one time, split into multiple faxes or submit another way.*

Email: appeals@fridayhealthplans.com

Mail: Attn: Appeals Dept., 700 Main St., Suite 100, Alamosa, CO 81101