

## 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 is not included, an appeal review may be delayed or 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](mailto:appeals@fridayhealthplans.com)

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