fridayhealthplans.com
844-465-5500

Friday Health Plans of North Carolina, Inc.
700 Main Street
Alamosa, CO 81101

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