



Friday Health Plans of Colorado, Inc.

fridayhealthplans.com
844-805-5000

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 <input type="checkbox"/>		Authorization <input type="checkbox"/>
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, <i>please do not fax more than 100 pages at one time, split into multiple faxes or submit another way.</i> Email: appeals@fridayhealthplans.com Mail: Attn: Appeals Dept., 700 Main St., Suite 100, Alamosa, CO 81101			