Provider Appeal Request Form

Please utilize this form to request a Provider Appeal.

Note: Requests must be submitted within 30 calendar days of the claim denial. Appeals may be sent individually or as a batch of similar or like claims. Please complete the appropriate section for resubmission type.

IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

INDIVIDUAL CLAIM APPEAL

Provider Name: _____ Provider Number: _____
(PSHP #, Medicaid #, or TIN)

Control Number: _____ Date (s) _____
(Located on your EOP directly beneath the patient name)

Member Name: _____ Member Number:_____

REASON FOR REQUEST:

- ☐ Denied for no authorization: authorization # _____ obtained
- ☐ Denied for no authorization: no referral required
- ☐ Denied for timely filing in error (please attach proof of timely filing)
- ☐ Paid to incorrect provider
- ☐ Incorrect payment amount
- ☐ Other (please explain below)

_____

_____

BATCH SUBMISSION OF SIMILAR/LIKE CLAIMS FOR APPEAL

Provider Name: _____ Provider Number: _____

Of Claims attached_____ Control Claim Numbers: _____
(Located on your EOP- attach list or write on claim)

Explain the Issue in detail:

_____

_____

Note: A photocopy of this form is permissible. **Mail completed form (s) and attachments to:**
Peach State Health Plan
P.O. Box 3000, Farmington, MO 63640