



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: Mail completed form (s) and attachments to:

Peach State Health Plan
P.O. Box 3000
Farmington, MO 63640
A photocopy of this form is permissible.