Claims Appeal Request Form – Provider Submission

Use this form to request an appeal of a previously adjudicated claim.

SECTION I: PROVIDER INFORMATION

Provider Name: _____

Provider NPI Number:_____ Tax ID Number (TIN): _____

Contact Name: _____ Phone Number: _____

Fax Number: _____ Email Address:_____

Mailing Address:

Street: _____ City: _____ State: _____ Zip: _____

SECTION II: MEMBER INFORMATION

Member First Name: _____ Member Last Name: _____

Member ID Number: _____ Date of Birth: ___ / ___ / _____

SECTION III: CLAIM INFORMATION

Claim Number: _____ Date(s) of Service: ___/___ /_____ to ___/___ /_____

Total Billed Amount: $_____ Date of Original Claim Submission: ___ / ___ / _____

SECTION IV: APPEAL TYPE (Select One)

☐ Payment Dispute ☐ Denial for Authorization ☐ Timely Filing Denial ☐ Coding Dispute

☐ Coordination of Benefits ☐ Other (please specify): _____

SECTION V: REASON FOR APPEAL

Explain in detail the reason for your appeal. Attach supporting documentation such as the original Explanation of Payment (EOP), medical records, corrected claim, authorization, referral, etc.

_____

_____

_____

_____

SECTION VI: REQUIRED ATTACHMENTS

☐ Copy of EOP or Remittance Advice ☐ Medical Records ☐ Authorization/Referral

☐ Corrected Claim ☐ Other Supporting Documentation (Specify): _____

SECTION VII: ATTESTATION

I hereby attest that the information provided in this form and all attached documentation is accurate to the best of my knowledge.

Print Name: _____

Signature of Provider Representative: _____

Date: ___ / ___ / _____

SUBMISSION INSTRUCTIONS

Mail or Fax Completed Form and All Attachments to:

LITTLE HAVANA ACTIVITIES & NUTRITION CENTERS OF DADE COUNTY, INC.
700 SW 8TH STREET
MIAMI, FL 33130
ATTN: CLAIMS DEPARTMENT

Phone (for questions): 1-844-776-0593

Email: Claims@Lhanc.org