

# ADMINISTRATIVE APPEAL REQUEST

Date: \_\_\_\_\_

## Member Information

Member name: \_\_\_\_\_

County of residence: \_\_\_\_\_ MAID number: \_\_\_\_\_

Primary insurance: \_\_\_\_\_ Secondary insurance: \_\_\_\_\_

## Provider Information

Provider name: \_\_\_\_\_

Provider site address: \_\_\_\_\_

Contact person's name: \_\_\_\_\_

Contact person's address: \_\_\_\_\_

Phone number: \_\_\_\_\_ NPI: \_\_\_\_\_ TIN: \_\_\_\_\_

## Appeal Information

Date(s) of service to be reviewed: \_\_\_\_\_

Type of service: \_\_\_\_\_ CPT code: \_\_\_\_\_ Modifier: \_\_\_\_\_

Authorization number: \_\_\_\_\_ Claim number: \_\_\_\_\_

Total dollar amount requested: \_\_\_\_\_

Provider's requested action:

\_\_\_\_\_  
\_\_\_\_\_

Reason for denial:

\_\_\_\_\_  
\_\_\_\_\_

Steps taken to correct and prevent future occurrences (if applicable):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Additional Information

Please submit additional documental of services rendered, such as EVS verification or any other documentation that will support the request. Please include a typed narrative of additional supporting documentation to justify the request.