healthEZ

Provider Appeal Form

Please complete all requested information and submit it to the Appeals Team for review.

PROVIDER INFORMATION

Today's Date:	Provider TIN:	Provider NPI:
Provider or Facility Name:		Network:
Address:	City:	State: Zip:
Phone: ( )	Fax: ( )	Email:

SUBMITTED BY

Name	Phone	Fax

APPEAL INFORMATION

Subscriber Name	Date of Birth	Member ID Number
Explanation of Payment Number	Claim Number	Group/Plan Name
CPT Code(s)	Denial Code:	Billed Amount

Review Type: Place an 'X' in one of the boxes below and provide a comment to reflect the purpose of the review submission.

	Contract Term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms. Please provide a copy of the network contract.
	Out of Network: The provider believes the previously processed claims should have been paid using network pricing. Please attach proof of your network contract.
	Corrected Claim: This is a previously processed claim, either paid or denied, that requires an attribute correction, e.g. units, procedure, diagnosis, modifiers. Please specify the correction to be made in the box below.
	Duplicate Claim: The claim denied as a duplicate claim. Please submit medical records or clarification of your corrected claim.
	Filing Limit: This is a claim whose original reason for denial was untimely filing. Please provide proof of timely submission.
	Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy. Please submit medical records.
	Pre-Certification/Notification or Prior-Authorization or Reduced Payment: This is a request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
	Request for Additional Information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (Coordination of Benefits (COB), Accident, Home Infusion Therapy). Please include supporting documentation
	Retraction of Payment: The provider is requesting a retraction of entire payment or service line e.g. not your patient, workers comp, service not performed.

	Other: Please describe in detail below
Comments (Please print clearly):	

Submit completed form via email to Appeals@HealthEZ.com or Fax to: 952-255-6380
or Mail to: HealthEZ
PO Box 211186
Eagan, MN 55121

Please call Provider Service at 844-449-5553 with any questions.

APPEAL SUBMISSION

You must submit this completed form to us along with the Explanation of Payment and/or any supporting documentation for reference. A separate form must be completed for each appeal.

Signature of person submitting this appeal