

Provider Appeal Form

Please complete the following information entirely and return this form with supporting documentation to the applicable address listed below. Send only one appeal per claim.

- Before filing an appeal, Please review and ensure filing an appeal is appropriate.
- If a claim has not been acted upon, i.e., not paid or formally denied, please verify claims status first.
- If the claim has been returned for insufficient or incorrect information to be corrected, please submit this action before submitting an appeal.
- Provider relevant supporting documentation, including but not limited to: copy of claim, explanation of payment, medical records, and previous related correspondence. If sufficient information is not included, an appeal review may be delayed or not conducted.

Date: _____ Type of Appeal: Claim Authorization

Provider/Group/Facility Information

Provider/Group/Facility Name:

Provider TIN/NPI Number:

Contact Name:

Phone Number:

Fax Number:

Email Address:

Address:

Apt./Suite:

City:

State:

Zip Code:

Member Information

Last Name:

First Name:

DOB:

Member ID Number:

Address:

Phone Number:

Claim Information

Provider

Facility

Ancillary Health Care Professional (DME, lab, ect.)

Claim #:

Authorization # (if applicable)

DOS:

Billed Amount:

Paid Amount:

State reason for Appeal:

Submission Options: Fax, email, mail

Fax: 844-280-1794, *please do not fax more than 100 pages at one time, split into multiple faxes or submit another way.*

Email: appeals@fridayhealthplans.com

Mail: Attn: Appeals Dept., 700 Main St., Suite 100, Alamosa, CO 81101