PROVIDER APPEAL FORM

Use this form as part of the Delaware First Health request for formal administrative claim appeal for re-evaluation or exception to a plan policy or contract requirement such as benefit limitations, eligibility, failure to obtain authorization or unsupported timely filing.

Name/ Address of person submitting appeal: Click or tap here to enter text.	Date: Click or tap here to enter text.
Provider Name: Click or tap here to enter text.	Provider Tax ID Number: Click or tap here to enter text.
Control/claim Number: Click or tap here to enter text.	Date(s) of service: Click or tap here to enter text.
Member Name: Click or tap here to enter text.	Member ID Number: Click or tap here to enter text.

Reason for appeal:

☐ Claim was denied for no authorization, but authorization # _____ was obtained

☐ Claim was denied for no authorization, but no authorization is required for this service

☐ Claim was denied for untimely filing error (attach proof of timely filing)

☐ Claim was denied for global/ unbundled procedure (attach medical records)

☐ Claim was denied for benefit limitations

☐ Other (please explain): we didn't get an authorization because xyz …

_____

_____

_____

_____

Mail completed form and attachments to:
Delaware First Health
Appeals Department
P.O. Box 8001
Farmington, MO 63640-8001