CareFirst Community Health Plan District of Columbia

# Formal Administrative Claim Appeal

Date: _____

**Claim Information:**

Claim#: _____

Member Name: _____

Member ID#: _____

Date of Service: _____

Date of EOB: _____

**Requestor/Responder Information:**

Name: _____

Contact#: _____

Fax#: _____

Address: _____

_____

Type of Claim: ☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME ☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: _____

Amount in question: $_____

Provider Name: _____

Group/Facility Name: _____

TIN/NPI#: _____

**Reason for Appeal/Review of Medical Records**:

Explain exactly what you are requesting ***CareFirst CHPDC*** to review. Attach copy of claim, EOB and other supporting documentation. *Only submit Medical records if they have been requested. This form should not be used for denials based on medical necessity.*

☐ Corrected Claim
☐ Not paid at contracted rates
☐ Denied for Lack of Authorization
☐ Processed with incorrect TIN
☐ Timely Filing (PROOF REQUIRED)
☐ Refunds/Stop payments
☐ Payment Appeal
☐ No Referral
☐ Coordination of Benefits (COB)
☐ Denied duplicate in error
☐ Processed PAR Provider as Out of Network
☐ Previously requested information attached
☐ Other

This form must be completed in its entirety or an appeal will not be processed. The entire submission will be returned to you if there is not enough information submitted for us to make a determination.