Formal Medical 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:_____

Claim amount in question: $_____

Provider Name:_____

Group Name:_____

Reason for Appeal/Review of Medical Records:

Explain exactly what you are requesting ***CareFirst CHPDC*** to reconsider. Attach copy of EOB and other supporting documentation. Medical records required when using this form.

__Denied Days _____

__Non-Clinical Reason: _____

__Service not covered

__Pre-Service Denial/Service Type:_____

__No Authorization

__Other (does not include administrative reasons, use the proper form for these types of appeals):

Form must be completed in its entirety or appeal will not be processed. Please note: this form is only to be used for claim denials that require a Medical Necessity decision. If the denial was based on an Administrative reason (like timely filing, billing issues, etc.) please use the Administrative Appeals form instead.