HealthPlans
A HARVARD PILGRIM COMPANY

Provider Appeal Form

Member ID* _____ **Member Name** _____

Date of Service _____ **Claim#** _____

Provider Name _____ **Appeal Submission Date** _____

Provider's Office Contact Name _____ **Provider Telephone#** _____

Please note the following in order to avoid delays in processing provider appeals:

- Incomplete appeal submissions will be returned unprocessed.
- A separate Provider Appeal Form is required for each claim appeal (i.e., one form per claim).
- Filing limit of the prevailing network applies.
- Include supporting documentation.

Appeal Type*—Check one box, and/or provide comment below, to reflect purpose of appeal submission.	**Required Documentation***—All bulleted items must be supplied from the row you check, along with the Provider Appeal Form and supporting documentation.
☐ **Filing Limit**—appeal request for a claim or appeal whose original reason for denial was untimely filing.	• 1500/UB claim form • Copy of EOP • Supporting documentation
☐ **Pre-certification/notification or prior-authorization denials**—appeal request for a claim whose original reason for denial was failure to notify or pre-authorize services.	• Copy of EOP • Supporting documentation
☐ Provider requesting **Retraction of Overpayment** (i.e., not your patient; service not performed; etc.)	• Copy of EOP • Along with the required documentation, supply additional information in the Comments section below.
☐ **Duplicate Claim**—appeal request for a claim whose original reason for denial was duplicate denial.	• 1500/ UB claim form • Supporting documentation
☐ Response to a claim previously denied for **request for additional information**	• Copy of EOP • Supporting documentation
☐ Submission of a **Corrected Claim**	• Copy of EOP • Corrected 1500/UB claim form
☐ Response to a claim previously denied on a remittance for **Other Insurance Primary, Coordination of Benefits (COB), Motor Vehicle Accident (MVA), or Worker's Compensation (WC)**	• Copy of EOP • Supporting documentation
☐ Request for reconsideration of a claim or appeals paid or denied incorrectly as a result of **contract rate, payment policy or clinical policy**	• Copy of EOP • Supporting documentation which would include detail of the inquiry

*Required element of an appeal.

Comments _____

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Where to mail this form: **Health Plans Inc., P.O. Box 5199, Westborough, MA 01581**

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