APPEAL DEPARTMENT
P.O. Box 5750
Springfield, MO 65801-5750

Toll Free: (800) 205-7665
Local: (417) 269-2900, option 5
Fax: (417) 605-3697

Provider Appeal Form

Before proceeding please note the following:

Corrected claims should be submitted to the claims address on the back of the patient's CoxHealth Medicare Advantage ID card. If you have received no payment to date for the claim in question and you are submitting requested documentation, please submit the documentation to the Claims Department.

Requests for review should include:

1. This completed form.
2. Reviews involving a Previous Clinical Denial should also include supporting documentation for issues such as denied hospital days, level of care, medical necessity, or service denied for no prior authorization.
   Supporting documentation should include a narrative describing the situation, an operative report, and medical records as applicable.

Member Name: _____ Member ID: _____

Provider Name: _____ Provider NPI: _____

Claim Number: _____ Claim Total: _____

Authorization Number: _____ Service Date: _____

Today's Date: _____

Please indicate below where appeal correspondence should be directed:

Name: _____ Phone: _____

Facility: _____ Fax: _____

Address: _____ _____ _____ _____

Street *City* *State* *Zip code*

State your reason for the appeal and the expected outcome below. Please attach supporting documentation.

If a decision is made to change the initial determination and issue additional payment, you may be notified of the payment adjustment through a Remit Advice (RA). If a decision is made to uphold our initial determination, you will be notified in writing.