**Today’s Date:** **Medical Group:**

**Member Information**

|  |  |
| --- | --- |
| Member Insurance plan |  |
| Member Last Name: | First Name: |
| Date of Birth: | Member Identification Number: |

**Physician/Provider**

|  |  |
| --- | --- |
| Contact Name: | Phone Number: |
| Practice/Facility Name: |  |
| Rendering Provider Name: | |
| Tax Identification Number (TIN): | NPI Number: |
| **Return Address information** |  |
| Street Address: | City: |
| State: | Zip: |

**Reason for Request**

|  |  |
| --- | --- |
| Date of Service: | Claim Number: |
| Total Charges: | Expected Amount Owed: |
| * 1. Previously denied / Exceeds Timely Filing: must provide proof of timely filing * 2. Previously denied requesting additional information: must include requested documentation * 3. Previously denied / Coordination of Benefits: must include Primary EOB * 4. Previously adjudicated but applied incorrect rate resulting in over/underpayment: Indicate details in comments * 5. Previously denied for “no authorization”: Indicate Authorization number or attach copy of authorization * 6. Other (Provide details below)   Comments – reason for appeal: | |

**Please include a copy of the initial claim, along with other documents supporting the request for an appeal and email to** [**appeals@innovista-health.com**](mailto:appeals@innovista-health.com)