

Provider Appeal Request Form	,
Member/Claim Information:	
Member ID #:	Member Name:
Claim #:	
Please give a brief description of why additional paymen	nt is warranted:
Instructions:	
 This form should be used for appeal requests only. Claim Resubmission Request Form. Be sure to attach all the following: 	If you are submitting a corrected claim, please use the
printout from a provider's own office system is - Any other pertinent information related to the 3. The form must be placed on top of all supporting	vas denied for being submitted beyond the filing limit. (A computer not acceptable proof of timely filing of claims.) service in question information you provide.
4. Submit one form for each claim you wish to appea	
Note: There is a 6-month limit to appeal from the a	late of the Explanation of Payment EOP statement that reflected

Contact Information In the event that ConnectiCare needs to contact the requester, please provide the following information:

the denied claim(s), and there is only one level of appeal for administrative appeals.

III tile event tila	it Connecticate needs to contact ti	ie requester, piease provide t	ne following information.	
Provider Name	:			
Provider ID#:		Provider NPI:		
Contact Name:				
Contact Phone	:	Contact Fax:		
Contact Addres	ss:			
	Town/City:	State:	Zip Code:	
Contact E-mail Address:				
Submit to:	ConnectiCare Attn: Provider Appeals			

Fax: (860) 674-7035

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