Provider Appeal Request Form

ConnectiCare VIP Medicare Plans

Member/Claim Information:

Member ID #: _____ Member Name: _____

Claim #: _____ Claim Date of Service: _____

Please give a brief description of why additional payment is warranted:

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Instructions:

1. This form should be used for appeal requests only. If you are submitting a corrected claim, please use the Claim Resubmission Request Form.
2. Be sure to attach all the following:
   - Operative Report or office chart notes, as applicable
   - Proof of timely filing if appealing a claim that was denied for being submitted beyond the filing limit. (A computer printout from a provider's own office system is not acceptable proof of timely filing of claims.)
   - Any other pertinent information related to the service in question
3. The form must be placed on top of all supporting information you provide.
4. Submit one form for each claim you wish to appeal.

Note: There is a 6-month limit to appeal from the date of the Explanation of Payment EOP statement that reflected the denied claim(s), and there is only one level of appeal for administrative appeals.

Contact Information

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

Provider Name: _____

Provider ID#: _____ Provider NPI: _____

Contact Name: _____

Contact Phone: _____ Contact Fax: _____

Contact Address: _____

Town/City: _____ State: _____ Zip Code: _____

Contact E-mail Address: _____

Submit to: ConnectiCare
Attn: Provider Appeals
175 Scott Swamp Road
Farmington, CT 06032-3124
Fax: (860) 674-7035

Print