Provider Appeal Request Form

Required documentation for Appeal:

- A completed Provider Appeal Form
- A **CMS-1500 form (02-12) and UB-04** Claim Form with all necessary corrections / modifications.
- Supporting documentation for reconsideration **(additional documentation should include the patient's medical records, operative notes, proof of timely filing, and any other documentation that supports your request).**

Provider Information:

Provider First/Last Name:_____

Phone:_____Address:_____

Medicaid ID (if applicable):_____ Claim #:_____

Contact Person:_____ Email Address:_____

Member Information:

Member First/Last Name:_____

Member ID:_____ Date of Birth:_____ Date of Service:_____

Reason for Denial:

☐ Untimely Filing ☐ No Valid Authorization ☐ Invalid Diagnosis / Modifier billing

☐ Other (Please Specify)_____

Service(s) Appealed:_____

Rational for Request:_____

_____

_____

Please mail or fax this form and all supporting documentation to:

Premier Eye Care
6501 Park of Commerce BLVD. Suite 100
Boca Raton, FL 33487
Fax: 855-818-4783
Attn: Appeals Department