



CLAIMS DEPARTMENT APPEAL SUBMISSION FORM

Provider Name: _____ Date of Appeal: _____

Group Affiliation: _____

Address: _____

Provider Contact Name: _____ Provider Contact Number: _____

Member Name: _____ Member Number: _____

Date(s) of Service: _____ Claim Number#: _____

Reason for Review:

- | | |
|---|---|
| <input type="checkbox"/> Additional Payment Requested | <input type="checkbox"/> Authorization included/attached |
| <input type="checkbox"/> Copy of Referral attached | <input type="checkbox"/> Date(s) of Service |
| <input type="checkbox"/> Denied in Error | <input type="checkbox"/> EOB Attached (COB claim) |
| <input type="checkbox"/> Incorrect Units | <input type="checkbox"/> Resubmission with Proof of Timely Filing |
| <input type="checkbox"/> Other Health Insurance | |

Carrier: _____

Primary Insured Name: _____

Policy# _____ Group# _____

Effective Date: _____ Term. Date: _____

Contact Name: _____ Phone# _____

Date Verified: _____

Additional Notes: _____

Other: _____

To expedite processing, return this form and a copy of the EOP, along with the any information related to appeal to:

Community First Health Plan
Attn: Claims Resolution Department
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

Keeping our commitment to you