



COMMUNITY FIRST
HEALTH PLANS

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: _____

Reason for Review:

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

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