COMMUNITY FIRST HEALTH PLANS

CLAIMS DEPARTMENT APPEAL SUBMISSION FORM

PROVIDER INFORMATION:

Provider Name: _____ Date of Appeal: _____

Group Affiliation: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Provider Contact Name: _____ Phone: _____

MEMBER INFORMATION:

Member Name: _____ Member ID #: _____

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

REASON FOR REVIEW:

- ☐ Additional payment requested
- ☐ Authorization included/attached
- ☐ Copy of referral attached
- ☐ Date(s)of service
- ☐ Denied in error
- ☐ EOB attached (COB claim)
- ☐ Incorrect units
- ☐ Resubmission (with proof of timely filing)
- ☐ Other health insurance (please provide the information requested below)

Carrier: _____ Effective Date: _____ Term Date: _____

Primary Insured Name: _____

Group #: _____ Policy #: _____

Contact Name: _____

Phone: _____ Date Verified: _____

Additional notes: _____

☐ Other (please explain) _____

_____

_____

_____

To expedite processing, return this form and a copy of the EOP, along with any information related to the appeal to:
Community First Health Plans
Attn: Claims & Appeals
PO Box 853927
Richardson, TX 75085-3927