Appeal Form

Instructions: This form is to be completed by providers to request a claim Appeal for members enrolled in a plan managed by CareCentrix. This form should only be used for claim Appeals; corrected claims & claim reconsiderations should not use this form.

Mail address: Send all Appeal requests to

CareCentrix, Inc.
Appeals Unit
PO Box 7779
London, KY 40742

***Please be advised, Federal Express, UPS and Certified Mail cannot be delivered to a Post Office Box, therefore, providers should send those claims to**

CareCentrix National Claims Center #1
Appeals Unit
1084 South Laurel Road
London, KY 40744

Do NOT use this form if changes have been made to this claim. If changes have been made to this claim, submit as a corrected claim, without this from and clearly mark "CORRECTED" on the claim submission. Please submit a separate appeal's form for each claim. Your appeal claim must be received by CareCentrix within 30 days from the date we orally advised or, for written requests for reconsideration, the date of our written notice (EOP, letter, etc.)

Patient Information

Name	**DOB**	**Intake ID**
Address:	**State**	**Zip Code**

Provider Information

Name	**TIN**	**NPI**
Address	**State**	**Zip Code**

Claim Information

Provider Invoice Number	**Service "From/To" Date**	**Original Amount Billed**
HCPCS/CPT and Modifiers Billed		**Original Amount Paid**
Claim Number	**Authorization Numbers(s)**	

Reconsideration Claim Information

Date of Reconsideration Claim EOP	**Reason For Reconsideration Claim Denial**

Please be specific when completing the description of dispute and the expected outcome, including dollar amount if possible.
Comments:

Contact Name:_____ **Date:**_____