

**Appeal Request Form**

If you are a member submitting an appeal, please complete the information below and include any additional medical records or documentation to support your appeal. If you have a copy of the claim or the Explanation of Benefits (EOB) please include a copy with your submission.

If you are a provider submitting a claim on behalf of a member, please include a copy of the EOB, a copy of the claim and any/all medical records and/or documentation to support your request for the appeal.

**Check appropriate box:**

<i>Processed Claim Appeal</i>	<i>Prior Authorization Appeal</i>	<i>Retro Authorization Request</i>

**Appeal is being filed by: Member \_\_\_ Physician \_\_\_ Facility \_\_\_ Other Representative \_\_\_**

If other representative, please note relationship to member: \_\_\_\_\_

<i>Appellant Contact Name</i>	<i>Appellant Contact Phone Number</i>	<i>Appellant Contact Fax Number</i>

**Please complete the following information:**

<i>Today's Date</i>	<i>Group Name</i>	
<i>Member's First Name</i>	<i>Member's Last Name</i>	<i>Member's ID number</i>
<i>Patient's First Name</i>	<i>Patient's Last Name</i>	<i>Patient's Date of Birth</i>
<i>Name of Provider</i>	<i>Provider's TIN/NPI</i>	<i>Provider's Phone Number</i>

<i>Claim Number</i>	<i>Claim Date of Service</i>

<i>CPT/HCPCS/Service Being Disputed</i>
<i>Explanation of your request (please submit additional pages if necessary)</i>

**Please fax your appeal to: (586) 238-4363**

**You may also mail your request to:** Appeals Department, PO Box 321125, Detroit MI 48232

If you are a provider submitting an urgent request for a prior authorization denial, please mark urgent and include supporting documentation as to why the urgent review is necessary.

**Urgent Pre-Service Appeal**