Appeal Request Form

NOTE: Completion of this form is mandatory. To obtain a review submit this form as well as information that will support your appeal, which may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list) to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Meritain Health®.

Today's Date	**Member Name**	**Member's ID Number**	**Member's Group Number**
06/22/2021			

Patient First Name	**Patient Last Name**	**Birthdate** (MM/DD/YYYY)

NOTE: An authorization form maybe required for the appeal if other than the member/patient.

Type of Appeal

Medical ☐ Dental ☐ Vision ☐

What are you appealing?

Medical Necessity/Precertification	☐	Co-ordination of Benefits	☐
Pricing dispute (amount allowed)	☐	Coding Dispute	☐
Benefit Level (percentage paid)	☐	Exclusion	☐
Pre-Service	☐		

Provider Name	**TIN**
Provider Address (Where appeal/complaint resolution should be sent)	
Claim(s)	**Date of Service(s)**
CPT/HPCS/ Service Being disputed	
Explanation of your request (please use additional pages if necessary)	

Please return to:
Meritain Health Appeals Department
PO Box 41980
Plymouth MN 55441
Fax: 716-541-6374