P.O. Box 30192
Salt Lake City, UT 84130-0192
selecthealthphysician.org

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Provider Appeal Form

Date _____

Provider Name _____ Office Contact _____

Address _____ City, State, ZIP _____

Telephone (_____) _____ Fax (_____) _____

Patient Name _____ Subscriber ID _____

Date of Service _____ Billed Amount _____

SelectHealth® Claim # _____ Auth # _____

Claim denial reason: Code _____ Description _____

Place of Service: ❑ Office ❑ ER ❑ Outpatient ❑ Inpatient (including SNF, Rehab) ❑ Home ❑ Other

Notes Attached (additional notes and/or documentation required for all appeals to be reviewed)

❑ Yes ❑ No ❑ See iCentra ❑ See EpicCare

Are you submitting a corrected claim?

❑ Corrected Diagnosis ❑ Corrected Date of Service ❑ Corrected Charges ❑ Corrected POS

❑ Corrected Procedure Code ❑ Addition or Correction of Modifier ❑ Corrected Provider Info

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Are you disputing a claim denial for one of the following reasons?

❑ Timely Filing ❑ Additional Information Needed ❑ Not Covered Service ❑ Benefit/Qty Limit

❑ No preauthorization obtained ❑ Unlisted Code ❑ Documentation does not verify services billed

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Are you disputing a National Correct Coding Initiative (NCCI) or Correct Coding Editor (CCE) coding edit?

❑ Assistant Surgeon Disallow ❑ Multiple Surgery ❑ Duplicate Service ❑ Other

❑ Bundled (subset, same day disallow, inclusive) Is there a source that supports your appeal?

_____ i.e. CPT manual, LCD/NCD, InterQual, AMA, etc?

Are you appealing a preauthorization or medical necessity denial?

❑ Does not meet criteria ❑ Experimental/Investigational ❑ Cosmetic ❑ Dental/TMJ ❑ Genetic Testing

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Are you disputing the overpayment/underpayment of a covered service?

❑ In vs. Out of Network Benefits ❑ Allowed amount dispute ❑ Preventive Care

Comments _____

Please fax completed form to: **801-442-6708**.