Post Service Claim Appeal Form

PROVIDERS: Do not use this form for claim reconsideration requests - please use the Claim Reconsideration Form.

Provider claim appeals must be received in writing within 90 working days from the date of the coverage decision as noted on your Explanation of Payments (EOP) or Explanation of Pending Payments (EOPP). Claim appeals submitted by members or member representatives must be received in writing within 180 calendar days from the date of the coverage decision as noted on your Explanation of Benefits (EOB) or Explanation of Benefits and Rights (EOBR).

The following are reasons for filing an appeal (*select those that apply*):

- ☐ Denial for Untimely Filing
- ☐ Non-Covered/Excluded Benefit
- ☐ Not Medically Necessary
- ☐ Incorrect Patient Responsibility Amount
- ☐ Benefit Maximum Reached
- ☐ Adverse Claim Reconsideration Decision
- ☐ Other (please describe): _____

_____

Required Appeal Information

Today's Date: ___/___/___

Is appeal from: ☐ **Member** or ☐ **Provider**

Provider Name: _____
Member Name: _____
Member ID: _____

Date of Service: ___/___/___ **Claim Number**: _____

Contact Name: _____ **Tel. Number**: _____

Mail or Fax all Information to:

Submit this Appeal Form to Attention:

Evergreen Health
Attn: Claim Appeals
3000 Falls Rd. Ste. 400
Baltimore, MD 21211
Fax: 888.975.1538
Email: claimsappeals@evergreenmd.org

To avoid delays in processing appeals:

- Include supporting documentation.
- Submit a separate form for each claim appeal.
- Applicable filing limit standards apply.