Medicare Non Contracted Provider Complaint and Appeal Request

NOTE: You must complete this form. It is mandatory. To obtain a review, you'll need to submit this form. Make sure to include any information that will support your appeal. This may be medical records, office notes, discharge summaries, lab records and/or member history (this isn't an all-inclusive list). Send this to the address listed on your Explanation of Benefits (EOB) or other correspondence received from us.

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type ☐ Medical ☐ Dental	Member's Group Number *(Optional)*

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*

Provider Name	TIN/NPI	Provider Group *(if applicable)*
Contact Name and Title		
Contact Address *(Where appeal/complaint resolution should be sent)*		
Contact Phone / Contact Fax	Contact Email Address	

To help us review and respond to your request, please provide the following information.
(This information may be found on correspondence from us.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)
Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)	
CPT/HCPC/Service Being Disputed		
Explanation of Your Request *(Please use additional pages if necessary.)*		

You may mail your request to:
Medicare Non Contracted Provider Appeals
PO Box 14067
Lexington, KY 40512

Or Fax us at: 1-724-741-4953

Here’s a Waiver of Liability form you can include with your request.

NOTE: To obtain a review, you’ll need to include this form along with the completed Waiver of Liability form. Make sure to include any information that will support your appeal. Please provide complete chart notes to include: History and Physical, Discharge Summary, Provider progress/office notes, Xray/laboratory results and/or Physical/Occupational/Speech therapy notes.

Waiver of Liability Statement

Enrollee's Name _____ Enrollee ID _____

Provider _____ Dates of Service _____

Health Plan _____

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature _____ Date _____