

Request for Claim Review/Appeal



INSTRUCTIONS FOR COMPLETING FORM:

1. Use only one form per review type/per member. You may attach more than one claim per review type
 2. Check the most appropriate box below for type of review requested
 3. Submit legible copies of CMS 1500 or UB 04 form to process your request accordingly
 4. Do not staple any documents
- * If you have a claim issue involving 25 claims or more, please contact your Claims Rep. so we may expedite corrections.

Fax Request to: (800) 452-3847 Or mail to: AvMed Health Plans, PO Box 569004, Miami, FL 33256

Member & Claim Information:

Member ID: _____ Date of Service: _____
Last Name: _____
First Name: _____ Claim Number: _____

Provider Information:

Provider Number: _____
Provider Name: _____ Tax Identification (EIN): _____
Provider Contact: _____

Indicate the Reason for Review/Appeal:

- Corrected Claim:** Units, Service Code (CPT/HCPCS/Rev), Member ID, Other: Please Explain Below
- Claim Paid Incorrectly:** Units, To Wrong Provider/Address, Not in accordance with contract
- Coding Guidelines:** (CPT Bundling/Unbundling): Please include explanation/justification for additional reimbursement
- Timely Filing:** Please include explanation for the untimely filing along with supporting documentation (i.e. EOB from another carrier). Please note that the EOB must show proof of a timely submission to previous carrier for consideration.
- Invoice/Itemized Bill as per AvMed Health Plans request**
Note: The Invoice/PO must reflect the patient/member for which the services correspond.
- Overpayment Disagreement:** Attach a letter detailing the contested portion of your payment and provide the specific reason for contesting. Reference Number: SF _____
Please include the reference number for the original AvMed Health Plans refund request letter in your correspondence.
- Denial Review:** AE or GE – No Authorization, ED – Medical Necessity Not Established, EH – Late Notification
- DN– Missing Report or Notes, VZ – Pending Review of Medical Records**
- If the claim was denied for "No Authorization" but you believe an applicable authorization existed, please verify the authorization before submitting the review (via the provider web portal or calling 800-452-8633). All authorizations include services authorized, date range and facility where services were authorized. A mismatch in the authorization will result in an administrative denial.
 - All Requests for reconsideration must include all applicable office notes/medical records/requesting provider's ordering summary and an explanation indicating the reason an authorization was not obtained prior to the services rendered.
- Other Reason/Explanation:** _____

NOTE: Your contract allows for a specific time period to request a review or appeal. This date is calculated from the date of the original notice of payment or denial on the explanation of payment report. Late claim reviews or appeals cannot be considered.

TO REORDER ADDITIONAL FORMS CALL THE PROVIDER SERVICE CENTER AT 800-452-8633