Claim Appeal Form

Customer Service - **Phone**: 800-288-2078 | **Fax:** 312-906-8359 or **Mail:** Allied Benefit Systems, LLC P.O. Box 211651 Eagan, MN 55121

Allied Benefit Systems, LLC ("Allied") is the claims processor for the employer group health plan ("Plan"). To enable the Plan to review your appeal, the following information is required. Please complete the questions below and attach any supporting documentation along with your written appeal for review. Be sure to explain why you think the decision is not correct and claims(s) should be paid.

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- Have services been rendered?
  - If no, this is not an appeal of an adverse benefit determination. Please contact Customer Service at the number shown on the patient's ID card.
- Corrected claims should be submitted to the claim address on the back of the patient's Allied ID card. If you are submitting additional information for the initial review of payment, please forward to the address on the back of the patient's ID card.

NETWORK/CODING DISPUTES:

- Fee schedule or contract disputes must be directed to the PPO Network directly. Please refer to the patient's Allied ID card for the PPO Network utilized by the patient's Plan.
- Disputes of national coding and payment standards:
  - MARS- contact MARS directly
  - Cigna- contact Cigna Provider Relations directly
- Qualified Payment Amount/No Surprises Act (NSA/QPA):
  - Contact vendor that is listed on the Explanation of Benefits (EOB)

REQUESTS FOR REVIEW SHOULD INCLUDE:

- This completed form requesting an appeal review and indicating the reason(s) why you believe the claim payment is incorrect and should be reviewed.
- Include a copy of the original claim and the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable
- For reviews involving a previous clinical denial, such as denied hospital days, level of care, medical necessity or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable

Please check the box next to the issue that best describes your appeal. The initial decision was related to:

Medical Necessity

☐ Mutually exclusive, incidental, or bundling procedure code denial
☐ Unlisted Procedure Code
☐ Experimental/Investigational procedure
☐ Medical necessity of the service
☐ Cosmetic Denial
☐ Genetic Testing
☐ Drug Testing

Benefit Appeal Dispute

☐ Duplicate Denial of a Corrected Claim
☐ Timely Filing Denial
☐ Precertification or prior authorization not obtained
☐ Service paid out of network but requesting in network payment
☐ Benefit plan exclusion or limitation
☐ Coordination of Benefits
☐ Maximum Reimbursable Amount
☐ Misquote of Benefits
☐ Global Fee Denial
☐ Non-participating anesthesiologist, radiologist, or pathologist requesting in-network benefits

PLEASE COMPLETE AND REMIT FORM ALONG WITH SUPPORTING DOCUMENTATION:

**Asterisk denotes required field. Numeric fields do not require dashe*

Subscriber Information	
Subscriber First Name *	Subscriber Last Name *
Employer Group Number *	Employer/Group Name *
Subscriber ID *	

Patient Information	
Patient First Name *	Patient Last Name *
Relationship to Subscriber *	

Service Information	
Service Start Date *	Service End Date*
Provider Name *	Claim Number (if available)
Additional Service Dates (if applicable):	Additional Claim Numbers (if applicable):

Appeal Information	
Reason for Appeal *	
CPT code or Revenue code for Appeal *	Remark Code for CPT code or Revenue code in question (Please refer to EOB):

Requestor Information	
Contact First Name *	Contact Last Name *
Provider Billing Name *	Phone Number *
Mailing Address *	Fax Number*
Signature of Person Appealing *	Is the Member's Signed Authorization Form included? *