Print Form

Provider Request for Claim Review/Appeal

www.avmed.org/providers/tools/forms

AvMed HEALTH PLANS

THIS FORM IS NOT TO BE USED FOR MEMBER APPEALS
MEMBERS PLEASE CONTACT MEMBER SERVICES AT THE NUMBER LISTED ON YOUR ID CARD

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

TIPS TO AVOID DELAYS IN PROCESSING YOUR REQUEST

- Please submit only one form per patient.
- Attach appropriate supporting documentation (do not staple), such as applicable office notes/medical records/requesting provider's ordering summary and an explanation of why you believe a review/appeal is warranted.
- Complete all required fields. Information must be neatly typed and legible.

Please contact your Claims Representative for claim issues involving 25 claims or more.

Member and Claim Information (All fields are Required)

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

Provider Information (All fields are Required)

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

Review/Appeal Reason
You Must Check One of the Following:

Corrected Claim: ☐ Units ☐ Service Code (CPT/HCPCS/Rev) ☐ Member ID _____
☐ Other: Please Explain _____

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

☐ Denied No Authorization (AE or GE)
☐ Denied Medical Necessity Not Established (ED)
☐ Denied Late Notification (EH)
☐ Denied Missing Report or Notes (DN)
☐ Denied Pending Review of Medical Records (VZ)
☐ Other: _____

☐ Invoice/Itemized Bill as per AvMed Health Plans request (The Invoice/PO must reflect the patient/member for which the services correspond)

☐ 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.

☐ Overpayment Disagreement: Attach a letter detailing the contested portion of your payment and provide the specific reason for contesting. Reference Number found on refund request letter: SF_____

☐ Other Reason/Explanation: _____
_____
_____
_____