



Provider Request for Review

ALL INFORMATION MUST BE COMPLETED OR IT WILL BE RETURNED WITHOUT REVIEW

Review must be submitted within 180 days from remittance advice date

DATE _____

Claim Data:
Patient ID #:
Patient's Name:
Date of Birth:
Claim #:
Type of product (HMO, POS, PPO or Medicare Advantra):
Date of Service:
Provider Data:
Provider Name:
Provider TIN #:
Contact Person:
Phone Number:
Mailing Address:
Fax Number:
E-Mail Address:

APPEAL FOR CODING ISSUE WITH DOCUMENTATION ATTACHED	APPEAL WITH DOCUMENTATION ATTACHED
<input type="checkbox"/> Modifier usage (MCRN) <input type="checkbox"/> Surgery bundling/multiple proc. (MCRN) <input type="checkbox"/> Global days and/or surgery (MCRN) <input type="checkbox"/> Other coding issue (MCRN)	<input type="checkbox"/> Denied for no authorization (PCPR) <input type="checkbox"/> Denied for timely filing (PCPR) <input type="checkbox"/> Medical Necessity of diagnosis (PCHS) <input type="checkbox"/> Denied for Inpatient bed days (PCHS) <input type="checkbox"/> Pre-existing denial (PCHS)
OTHER - (CSO)	
<input type="checkbox"/> Corrected/Updated Claim <input type="checkbox"/> Explanation of Benefits (EOB)	
Comments: _____ _____ _____	

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