CODING APPEAL REQUEST FORM

PCHP/PAS/PIC ONLY

Any review request received after 60 days of the date of the initial claim remittance will not be eligible for consideration & the original processing of the claim will remain final. Please refer to Provider Appeals policy in Office Procedures Manual.

*Instructions: This completed form & all applicable attachments must be emailed to **appeals@preferredone.com**

Today's Date:

Billing Provider Information

Clinic Name:

Rendering Practitioner Name:

Tax ID Number:

Claim Information

Patient Name:

Patient ID Number:

Date(s) of Service:

Payer Claim Number:

Billed Amount:

Reason for Request:

Complete description of reason for claim auditing review request. ***This form MUST include nationally recognized coding rationale/sourcing that supports this request for review or the request will not be deemed complete & therefore ineligible for review.***

Attachments:

☐ Remittance Advice ☐ Nationally Recognized Sourcing Documentation **(REQUIRED)** ☐ Medical Records **(REQUIRED)**

Contact Information:

Requestor: Date: Contact tĸ2yŜ:

Provider Address:

Contact Fax:

Contact Email: