

**NON-PAR PROVIDER
APPEAL FORM**

Date _____

Please complete the following form to help expedite the review of your claims appeal.

Use the Provider Appeal Form to request a review of a decision by Arizona Complete Health. Please see the Provider Manual for details and requirements for the appeals process.

Provider Name*	Provider Tax ID*
Provider NPI*	Date of last Explanation of Payment
Arizona Complete Health Claim Number*	Date of Service*
Member Name	Member ID

* Indicates a required field

Reason for the appeal (please check all that apply):

Claim was denied for no authorization, but authorization number was obtained.

Claim was denied for no authorization, but no authorization is required for this service.

Claim was denied for Member not eligible, but member was eligible on DOS (attach eligibility information)

Claim was denied for incomplete or missing sterilization form, but one was submitted with claim (attach completed form)

Claim was not paid per the terms of my contract with Arizona Complete Health (attach relevant reimbursement section) Claim was denied "Past Timely Filing" (attach proof of timely filing)

Claim was paid the incorrect amount (include calculation of expected payment and supporting information)

Other: Please explain

Please ensure sufficient detail is provided to assist us in the review of your appeal.

Mail completed forms and all attachments to
Arizona Complete Health
Claims Reconsiderations & Disputes Department
PO Box 3060
Farmington, Missouri 63640-3800

Contact name & number of person requesting the appeal _____