CLAIM APPEAL REQUEST FORM
TRIAD Healthcare, Inc.
80 Spring Lane
PLAINVILLE, CT 06062
Fax: 860-793-3317

DATE: _____________

APPELLANT'S NAME: __________________________

Healthplan: __________________________ ID#__________________________________

Reference Numbers being appealed: ____

ADDRESS: ____

TELEPHONE NUMBER: BUSINESS: ____________________________________
HOME: ____________________________________
FAX: ____________________________________

Please provide the reason for requesting this appeal.
Include original issue/complaint, statement of original issue and brief summary.

List CPT Codes being appealed: __________ For Dates of Service: _______________

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List CPT Codes being appealed: _____________ For Dates of Service: _______________

(USE ADDITIONAL FORMS FOR ADDITIONAL CPT/DATES OF SERVICE)

PLEASE SUBMIT ANY ADDITIONAL SUPPORTING DOCUMENTATION, SUCH AS: OFFICE NOTES, MEDICAL RECORDS, DIAGONOSTIC STUDIES

I authorize and direct TRIAD Healthcare, Inc. to investigate the issues described above. I authorize any party identified above to release information pertaining to this investigation to TRIAD Healthcare, Inc. upon her/his written request.

____
Name

____ __________________________
Signature Date

Please indicate that you have sent all necessary clinical information to review this appeal Yes No

Will you be submitting additional information with this appeal Yes No

Please submit this form and all documentation in writing to the above address or fax to 860-793-3317.

TRIAD QM Department