



3250 Mary Street, Suite 400 Coconut Grove, FL 33133

Provider Appeal/Dispute Form

Date:	Member ID:	Member Name:
Date of Service:	Provider Name:	Claim#
Appeal Requestor Name:	Appeal Requestor Phone:	Appeal Requestor Address:

Please note the following in order to avoid delays in processing provider appeals:

- Incomplete appeal submissions will be returned unprocessed.
- Include supporting documentation.
- Non-Participating Providers, should include a waiver of liability unless the request is due to an underpayment.

Appeal Type -Check one box, and/or provide comment below, to reflect purpose of appeal submission.	Required Documentation -All bulleted items must be supplied from the row you check, along with the Provider Appeal Form and supporting documentation.
<input type="checkbox"/> Filing Limit -appeal request for a claim or appeal whose original reason for denial was untimely.	<ul style="list-style-type: none"> • Copy of EOB • Supporting Documentation
<input type="checkbox"/> Pre-certification/notification or prior authorization denials -appeal request for a claim whose original reason for denial was failure to notify or pre-authorize services.	<ul style="list-style-type: none"> • Copy of EOB • Supporting Documentation
<input type="checkbox"/> Response to a claim previously denied on a remittance for Other Insurance Primary, Coordination of Benefits (COB), Motor Vehicle Accident (MVA), or Worker's Compensation (WC)	<ul style="list-style-type: none"> • Copy of EOB • Supporting Documentation (could be evidence of payment collect from other payer)
<input type="checkbox"/> Authorization Discrepancy -Authorization on file does not match dates of services billed.	<ul style="list-style-type: none"> • Copy of EOB • Medical Records supporting the additional days not covered.
<input type="checkbox"/> Inpatient vs. Outpatient/Outpatient vs. Inpatient - Authorization discrepancy from the status called in to status billed.	<ul style="list-style-type: none"> • Copy of EOB • Medical Records (include physician orders reflecting the status the physician order or any changes in status made during the hospital stay.
<input type="checkbox"/> Non-Covered Medicare Service - not a Medicare covered services.	<ul style="list-style-type: none"> • Copy of EOB • Supporting Documentation(include LCDs from Medicare or any guidance that indicates the service provided is covered.
<input type="checkbox"/> No Criteria - services provided do not meet medical criteria.	<ul style="list-style-type: none"> • Copy of EOB • Supporting Documentation (include medical records that reflect that the service provided was truly needed.
<input type="checkbox"/> Underpayment - can include a claim that has been paid and the amount is being disputed. This reason can include, global claim denials, bundled and incidental.	<ul style="list-style-type: none"> • Copy of EOB • Supporting Documentation

Comments: _____

Please submit this appeal form with the required documentation electronically or by mail to the information below:

HealthSun Health Plans
 Attention: Appeals Department
 PO Box 330049
 Coconut Grove, FL 33233
 Fax number: (877)589-3256
 Email: Grievances&Appeals@healthsun.com