9250 W. Flagler St. Suite # 600, Miami, FL 33174

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.
☐ **Filing Limit**-appeal request for a claim or appeal whose original reason for denial was untimely.	• Copy of EOB • Supporting Documentation
☐ **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.	• Copy of EOB • Supporting Documentation
☐ 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)**	• Copy of EOB • Supporting Documentation (could be evidence of payment collect from other payer)
☐ **Authorization Discrepancy**-Authorization on file does not match dates of services billed.	• Copy of EOB • Medical Records supporting the additional days not covered.
☐ **Inpatient vs. Outpatient/Outpatient vs. Inpatient**-Authorization discrepancy from the status called in to status billed.	• Copy of EOB • Medical Records (include physician orders reflecting the status the physician order or any changes in status made during the hospital stay.
☐ **Non-Covered Medicare Service**- not a Medicare covered services.	• Copy of EOB • Supporting Documentation(include LCDs from Medicare or any guidance that indicates the service provided is covered.
☐ **No Criteria**- services provided do not meet medical criteria.	• Copy of EOB • Supporting Documentation (include medical records that reflect that the service provided was truly needed.
☐ **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.	• Copy of EOB • Supporting Documentation

Comments:____

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

HealthSun Health Plans
Attention: Appeals Department
9250 W. Flagler St. Suite # 600
Miami, FL 33174
Fax number: (877)589-3256
Email: Grievances@Appeals@healthsun.com