

PROVIDER APPEAL FORM
CCStpa

One form per appeal – MN Providers please use the AUC form to request an appeal

Today's Date: _____ Provider ID#: _____ Provider Name: _____

Your Name: _____ Phone #: _____ Fax #: _____

Return Address: _____

Patient Account Number: _____ NPI (National Provider Identifier) Number: _____

Member ID#:	Patient Name:	Claim #:
Group #:	Billed Charge:	Service Dates (all):

<p><u>INQUIRY</u> (Status check or claim adjustment) Fax all inquiries to (651) 662-2745</p>	<p>Use the Provider Inquiry form when you are requesting a reconsideration of a previously adjudicated claim, and you are submitting corrected data.</p>
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<p><u>APPEAL</u> Mail or fax to: EPNI Attn: Appeals Department PO Box 64668 Route W350 St. Paul, MN 55164-0668 Fax – (651) 662-2745 <input type="checkbox"/> Appeal / Reconsideration Request (Attach supporting documentation for your appeal) <input type="checkbox"/> 2nd Appeal / Dollar Amount in dispute must be over \$500 (Attach additional supporting documentation for your appeal)</p> <p><input type="text"/> Enter remark code found on Provider Web Self-Service. If unable to obtain remark code, please indicate your concern here:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>An appeal is a denial, reduction, termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment.</p>
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<p><u>Response</u> If we are able to complete the adjustment or approve the appeal as requested, we will not respond outside of your adjusted Statement of Provider Claims Paid.</p>

Indicate here if multiple related inquiries / appeals are being submitted for the same member.
Specify number in ____ of ____ format (e.g. 1 of 5, or 3 of 10).