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: ___________________

<table>
<thead>
<tr>
<th>Member ID#</th>
<th>Patient Name</th>
<th>Claim #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group #</td>
<td>Billed Charge</td>
<td>Service Dates (all)</td>
</tr>
</tbody>
</table>

INQUIRY  (Status check or claim adjustment)  
Fax all inquiries to (651) 662-2745

Use the Provider Inquiry form when you are requesting a reconsideration of a previously adjudicated claim, and you are submitting corrected data.

APPEAL  
Mail or fax to:  
EPNI  
Attn: Appeals Department  
PO Box 64668  
Route W350  
St. Paul, MN 55164-0668  
Fax – (651) 662-2745

☐ Appeal / Reconsideration Request (Attach supporting documentation for your appeal)  
☐ 2nd Appeal / Dollar Amount in dispute must be over $500 (Attach additional supporting documentation for your appeal)

Enter remark code found on Provider Web Self-Service. If unable to obtain remark code, please indicate your concern here:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Response  
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.

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).  

X17583 (9/09)