Mailing Address:
P.O. Box 38
Minneapolis, MN 55440-9984

Mail form to:
CoOportunity Health Claims
P.O. Box 38
Minneapolis, MN 55440-9984

Fax Form to: 1.651.265.1220

MEDICAL APPEAL REQUEST FORM

Claim Appeal requests include reconsideration of an adjudicated claim where the originally submitted data is accurate or a claim that was denied for timely filing. A CoOportunity Health claim number is required.

Provider Name _____

Billing Provider ID# NPI (preferred) or Tax ID _____

Contact Person _____ Phone/Fax/Email _____

Patient Member Number _____ Patient Name _____

Patient Account Number _____ CoOportunity Claim Number _____

First Date of Service _____ Billed Amount _____

Please check applicable reason(s) and attach all supporting documentation.
All appeals require a description of the request in the comments section below.

☐ **TIMELY FILING/Late Claims Submission Appeal**
APPEAL MUST BE MADE WITHIN ONE YEAR OF THE ORIGINAL DISALLOWED CLAIM.

- Attach a copy of the original claim showing the original print date OR a screen print from your billing system showing the account activity and the reason why the claim is/was submitted late.

☐ Pricing	Incorrect payment or application of benefits
☐ Eligibility Issues	Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
☐ Coding Review	Appeal of coding decision. Supporting documentation is required
☐ Medical Policy	Appeal a determination of medical necessity or application of benefits
☐ Credentialing	Professional credential information was incorrect or has been updated since claim processed
☐ Other	Provide a detailed description in the box below

Complete Description of Reason for Claim Adjustment:

SUPPORTING DOCUMENTATION ATTACHED: (PLEASE CHECK BELOW)

☐ New completed claim (HCFA/UB/ADA/other) ☐ Remittance Advice ☐ Refund ☐ Medical Records
☐ Spreadsheet ☐ Other (describe) _____