MEDICAL/DENTAL 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 HealthPartners claim number is required.

☐HealthPartners
Fully Insured and Self Insured Products
PO Box 1289
Minneapolis, MN 55440-1289
952-883-7770 or 7755
Fax 651-265-1230

☐HealthPartners
Senior/Medicare Products
State of MN Assistance/Medicare Products
Federal Employee Group
PO Box 9463
Minneapolis, MN 55440-9463
952-883-7699//888-663-6464
Fax 952-883-7666

☐HealthPartners
Dental Products
PO Box 1172
Minneapolis, MN 55440
952-883-5165//800-642-1323
Fax 952-883-5160

Provider Name _____

Billing Provider ID# NPI (preferred) or Tax ID_____

Contact Person _____ Email: _____

Phone# _____ Fax # _____

Patient Member Number _____ Patient Name_____

HealthPartners 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
REQUEST MUST BE MADE WITHIN 60 DAYS OF THE ORIGINAL DISALLOWED CLAIM.

- Check this box to appeal claims submitted after your contractual filing limits. If you have questions about your filing limit please contact your contracting representative.
- 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 related to member eligibility. Examples include: Payer sequencing, Paid ineligible charge, processed under incorrect member
☐Coding Review	Appeal of coding decision. Supporting documentation is required
☐Prior Authorization	Request for medical necessity review for claim(s) **Denied No Prior Authorization**
☐Credentialing	Professional credential information was incorrect or has been updated since claim processed
☐Other	Provide a detailed description in the box below

***** Fax number required above for Coding Review and Prior Authorization Review *****

Complete Description of Reason for Claim Appeal:

SUPPORTING DOCUMENTATION ATTACHED: (PLEASE CHECK BELOW)
☐New completed claim (HCFA/UB/ADA/other) ☐Remittance Advice ☐Refund ☐Medical Records
☐Spreadsheet ☐Other (describe) _____