CLAIM APPEAL REQUEST FORM

***Submit only one claim appeal per form**

Claim appeals may be filed with Envolve Vision in order to challenge any adverse determination. Please complete this form in full (print or type), attach the appropriate documents, and mail to the address below. Appeals must be filed within the number of days specified by the plan. Please consult your Provider Manual.

Today's Date: _____

Requesting Provider Name: _____

Claim Information:

Member ID Number: _____ Date of Service: _____

Member Name: _____ Service(s) Provided (CPT): _____

Member Date of Birth: _____ Envolve Vision Claim #: _____

Request for Review: Indicate the reason(s) this claim should be reconsidered.

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Please attach:

1. Claim specific correspondence from Envolve Vision (authorizations, referrals, etc.)
2. Documentation supporting the appealed claim (operative reports, medical records, chart notes, etc.) Documentation must contain information not submitted with the original claim. **If no additional documentation is provided, the original disposition will prevail**
3. The **original** CMS 1500 Form listing the appealed claim
4. For coordination of benefit issues, a copy of the other insurance carrier's EOB/EOP

MAIL COMPLETED FORM TO:
Envolve Vision, Inc.
Attn: Appeals Department
P.O. Box 7548
Rocky Mount, NC 27804

For Internal Use Only:

Date Received: _____ **Committee Date:** _____

Notification Send Date: _____ **Committee Decision:** _____

Date Claim Adjusted: _____