envolve
Benefit Options

CLAIM APPEAL /RECONSIDERATION REQUEST FORM

☐ VISION ☐ DENTAL

PLEASE CHECK ONE

CLAIM APPEAL /RECONSIDERATION REQUEST FORM

* Submit only one claim appeal per form *

Please complete the following form to help expedite the review of your claim appeal / reconsideration request. Please email or mail the completed form in full (print or type), with the appropriate documents. Providers are allowed **ONE** reconsideration request per claim. Appeal / Reconsideration must be filed within the number of days specified by the plan. Please consult your Provider Manual.

REQUEST FOR ☐ **APPEAL** ☐ **RECONSIDERATION** (PLEASE CHECK ONE)

Date / / (MM DD YYYY)

Requesting Provider Name

Requesting Provider NPI

Requesting Provider TIN

CLAIM INFORMATION:

Member ID Number

Member Date of Birth / / (MM DD YYYY)

Member First Name

Member Last Name

Date of Service / / (MM DD YYYY)

EBO Claim Number

Procedure/Service Code(s)

Indicate the reason(s) for this request (must select one) :

☐ Claim was denied for no authorization, but authorization number was obtained.

☐ Claim was denied for untimely filing in error (attach proof of timely filing)

☐ Claim was denied for Member not eligible, but member was eligible on DOS (attach eligibility information)

☐ Denied as duplicate in error

☐ Coordination of Benefits

☐ Other: Please explain below

Supporting comments / explanation:

Submitted by

Date / / (MM DD YYYY) Phone - -

Please submit form with documentation via Email or Mail to:

1. Documentation supporting the appealed / reconsidered 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 .**
2. Claims specific corresponsdence from Envolve Benefit Options (authorizations , referrals , etc.).
3. For coordination of benefit issues , a copy of the other insurance carrier' s EOB/EOP.

VISION CLAIM APPEAL / RECONSIDERATION:
EMAIL: *Envolve_AppealsandRecons@envolvehealth.com*

MAIL: Envolve Vision, Inc.
Attn: QI-Appeals
P O Box 7548
Rocky Mount, NC 27804

DENTAL CLAIM APPEAL / RECONSIDERATION:
EMAIL: *dentalappeals@envolvehealth.com*

MAIL: Envolve Dental
Attn: QI-Appeals
P O Box (refer to Provider Manual)
Tampa, FL 33622