**MEMBER APPEAL REQUEST**

**PRINT**

**INSTRUCTIONS:**

Complete the form below. **Fields with an asterisk (\*) are required.**

* Please complete this form if you are seeking reconsideration of a previous determination.
* Be specific when completing REASON FOR APPEAL AND REQUESTED OUTCOME.
* Provide additional information to support the reason for the appeal and include a copy of any balance billing statement, explanation of payment.

**Mail or fax completed form and attachments within 180 days of the previous determination to:**

|  |
| --- |
| Keenan EBTPA |
| Attn: Appeals |
| 888-773-7218 phone |
|  |
| **Fax to:** 310-533-5755 |
| **Mail to:** PO Box 2744, Torrance, CA 90509 |

|  |
| --- |
| **\*Provider Name** |
| **Provider Address** |

**Provider Type**  MD  Mental Health  Hospital  ASC  SNF  DME  Rehab

Home Health  Ambulance  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Claim Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Patient Name** | | **\*Date of Birth** | |
| **\*Member ID #** | **Patient Account #** | **\*Original Claim ID #(s)** | |
| **\*Service Dates** | **Tracking #** | **\*Original Billed Amount** | **\*Original Paid Amount** |

**Appeal Type**  Authorization  Member Responsibility  Eligibility

Non-Covered Service  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **\*Reason for Appeal and Requested Outcome/**900-character limit(Additional documentation may be attached as needed) |

           

Contact Name Relationship to Patient Phone Number

     

Signature Date Fax Number