**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