Request for Claim Review Form

Mail this form, a listing of claims (if applicable), and supporting documentation to:

NH Healthy Families
Attn: Provider Appeals
P.O. Box 4060
Farmington, MO 63640-3831

A provider appeal is a request from a health care provider to change a decision made by NH Healthy Families related to a denial or payment for services already provided. A provider appeal is **not** a pre-service appeal of a denied or reduced authorization for services, a complaint, a corrected claim, a reconsideration or adjustment request, or a claim resubmission.

Submitter/contact information:	
Name (last, first):	Phone number:

Provider information (correspondence):	
Name (last, first):	Phone number:
Provider address:	City, State, Zip:
NPI number:	Tax ID:
Date:	
☐ Participating Provider ☐ Non-Participating Provider	

Member information:	
Name (last, first):	Member date of birth:
Member ID:	

Claim information:	
Claim number:	Billed amount: $
Date(s) of services:	

To ensure timely and accurate processing of your request, please complete the claim review section below by checking the applicable reason for your request and attach documentation to support the request. Documentation should include a copy of the remittance advice, a narrative explaining why you are disputing denial of the claim(s), and supporting clinical when applicable.

Reason for claim review:

☐ Appeal: Inaccurate payment
☐ Appeal: Post-service authorization denial
☐ Appeal: Denied as a duplicate
☐ Appeal: Clinical edit limitation or denial
☐ Appeal: Denied for no primary payer EOB (EOB attached)
☐ Appeal: Denied for no authorization (service does not require authorization)
☐ Appeal: Denied for no authorization (authorization number on file: _____)
☐ Appeal: Untimely filing (proof of timely filing attached)
☐ Other: _____

Additional information: