

Appeal Form for Provider Billing Dispute and Medical Necessity Denial

Physicians and other health care professionals may appeal an Asuris claim payment decision by completing this form and faxing it to the number below along with any supporting documentation.

This form is appropriate for a dispute between a provider and Asuris about: (i) application of coding and payment rules and methodologies for fee for service claims submitted for payment (e.g., bundling, downcoding or application of a CPT modifier) or (ii) a denial stating a service is not medically necessary.

Please do not use this form to submit a corrected claim or a member appeal.

Date: _____	Provider Office Contact: _____
Provider Tax ID: _____	NPI #: _____
Provider Name: _____	Telephone Number: _____
Provider Billing Address: _____	
Member Name: _____	Member Date of Birth: _____
Member ID# (include alpha prefix, if known): _____	
Claim Number(s): _____	Date(s) of Service: _____
Has this claim(s) been appealed to Asuris before?	
___ Yes. If yes, please supply a copy of the appeal determination letter.	
___ No	

Include the following information when submitting this form:

- Reason for appeal
- Outcome desired
- Asuris appeal determination letter if this claim has been appealed before
- Supporting documentation. Examples include:
 - Operative report(s)
 - AMA-related article(s)
 - Chart notes

Fax to: 1 (866) 273-1820

