Hennepin Health

Provider Appeal Form

This form is used when a provider:

- After Claim Adjustment /Reconsideration Request has been reviewed and denial maintained, Providers have the right to appeal the decision by filing a provider appeal.

Date:_____

Please send this form to:
Hennepin Health
Attn. Provider Appeals Department
400 South 4th St. Ste 201
Minneapolis, MN 55415

Or fax this form to: 612-321-3786

PROVIDER INFORMATION:

Provider Name: _____
Provider NPI#: _____
Provider Address: _____
Provider Tax ID#: : _____

CLAIMS INFORMATION:

Member Name: _____
Member Number: _____
Date(s) of Services: _____
Claims Number(s): _____

REASON FOR REQUEST:

- □ Coding Review
- □ Restricted Recipient
- □ Medical Policy /Certificate of Medical Necessity
- □ Timely Filling of Claims Submission
- □ Eligibility Issue
- □ Credentialing Professional credential was incorrect or has been update since claim processed

EXPLANATION APPEAL:

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CONTACT INFORMATION

Requestor: _____Phone Number:_____
Requestor Address:_____

TOTAL NUMBER OF PAGES:____

For Hennepin Health Claims Department Use Only

Adjusted by:_____

Comments:_____
_____