
# Claims Payment Appeal Form

*Note: Appeals must be received within 60 days of notification of a denial or payment issue (i.e. within 60 days of the EOB date). Please be sure to include any documentation supporting your appeal.*

Provider of Service (Physician or Facility) | Medicaid Number

Address (Number, City, State, Zip)

Telephone # | Fax #

Contact Person | Date

## Claim Summary Information

Member Name | Member ID | DOB

Claim Number from EOB | Date of Service

Reason for Appeal (Check all that apply): ☐ Payment Issue ☐ Timely Filing ☐ Authorization Issue

Notes: ☐ Requested Documentation Attached ☐ Other: _____

**Please provide a detailed explanation for appeal**. Be sure to include all supporting documentation; i.e. copy of denial from EOB, copy of original claim, copy of electronic submission confirmation form for timely filing, pertinent clinical notes, etc. Attach additional sheets as necessary. _____

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**For payment dispute appeals – mail completed form and documentation to:**
**CMS/MMA (c/o Med3000)**
**P.O. Box 981648, El Paso, TX 79998-1648**

**For appeals relating to authorizations – mail completed form and documentation to:**
**CCP / CMS Claims Appeals**
**1643 Harrison Parkway, Building H Suite 200, Sunrise, FL 33323**

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