Independence
Independence Administrators

Submit to: **Independence Administrators**
Administrative Appeals
P.O. Box 21545
Eagan, MN 55121

FAX to: (215) 761-0956

YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED.
SIGNATURE MUST BE COMPLETE AND LEGIBLE. THIS FORM MUST BE DATED.

A. Provider Information

1. Provider Name:		**2. TIN/NPI:**
3. Provider Group (if applicable):		
4. Contact Name:		**5. Title:**
6. Contact Address:		
7. Phone:	**8. Fax:**	**9. Email:**

B. Patient Information

1. **Patient Name**: 2. **Ins. ID**:

3. **Did you attach a copy of** (check the appropriate response):

a. Explanation of Benefits/Explanation of Payment? ☐ Yes ☐ No ☐ NA

b. The **Consent to Representation in Appeals of Utilization Management Determinations and Appropriate Consent Form?**
(Consent form is **required for review of medical records** if the matter goes to arbitration.) ☐ Yes ☐ No

C. Claim Information

1. **Claim Number** (if known):

2. **Date of Service**:

3. **Authorization Number**:

4. **Claim filing method** (check only one):
a. ☐ electronic (**submit** a copy of the electronic acceptance report from our clearinghouse or us)
b. ☐ facsimile (**submit** a copy of the fax transmittal)
c. ☐ paper claim by mail or courier service (**submit** a copy of the delivery confirmation evidence)

5. **Check the reason(s) why you are filing this appeal** (**check all that apply and be specific about billing codes and reason for dispute**):
a. ☐ Action has not been taken on this claim
b. ☐ Dispute of a denied claim → provide **date of denial**: _____
c. ☐ Claim was paid but not in a timely manner (provide more information):
☐ Yes ☐ No Additional information was requested? If yes, date:_____
☐ Yes ☐ No Additional information provided? If yes, date: _____
☐ Yes ☐ No Prompt Payment Interest paid correctly?
d. ☐ Claim was paid, but the amount paid is in dispute
e. ☐ Codes in dispute _____/_____/_____/_____/_____/_____/_____/
f. ☐ Dispute of an overpayment or the amount of overpayment (Attach a copy of overpayment request)

D. Reason for Appeal (Required)

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Provider Name: _____ Contact Number:_____

Member Name :_____ DOS:_____

You may provide additional information in an attachment to explain why you are disputing our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Explanation(s) of Payment.
- A statement specifying the line items that you are appealing.
- Information we previously requested that you have not yet submitted, if available.
- Itemization of the provider contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract.
- Pertinent correspondence between you and us on this matter.
- A description of pertinent communications between you and us on this matter that were not in writing.
- Other documents you may believe support your position in this dispute (this may include medical records).

Attachments: ☐ **Yes** ☐ **No**

Signature:_____Date: _____

Important to Note

In order to ensure your Appeal is eligible to meet processing requirements, please make sure of the following:

- **The Appeal Form must be sent to the address posted on our website;**
- **The Appeal Form must have a complete signature (first and last name);**
- **The Appeal Form must be dated;**
- **There is a a signed and dated Consent to Appeal Form and/or and Authorization to Release Medical Records.**