Claims Coding Appeal Request Form

Any review request received after 60 days of the date of the initial claim remittance will not be eligible for consideration & the original processing of the claim will remain final. Please refer to Provider Appeals policy in Office Procedures Manual.

Return completed form and documentation to: Aspirus Health Plan, Attn: Appeals, PO Box 1062, Minneapolis, MN 55440 or email to appeals@preferredone.com.

PATIENT CLAIM INFORMATION

Patient Last Name	Patient First Name	Member ID	Patient Date of Birth

Address	City	State	Zip Code

Date(s) of Service	Payer Claim Number	Billed Amount

BILLING PROVIDER INFORMATION

Requester Contact Name	Email Address	Phone Number	Fax Number

Provider Clinic Name	Rendering Practitioner Name	Tax ID Number

Provider Address	City	State	Zip Code

REASON FOR APPEAL REQUEST

Complete description of reason for claim auditing review request. **This form MUST include nationally recognized coding rationale/sourcing that supports this request for review or the request will not be deemed complete & therefore ineligible for review.**

ATTACHMENTS

☐ Remittance Advice ☐ Nationally Recognized Sourcing Documentation *(REQUIRED)* ☐ Medical Records *(REQUIRED)*