Provider Appeal Form

Please complete the following information entirely and return this form with supporting documentation to the applicable address listed below. Send only one appeal per claim.

- Before filing an appeal, Please review and ensure filing an appeal is appropriate.
- If a claim has not been acted upon, i.e., not paid or formally denied, please verify claims status first.
- If the claim has been returned for insufficient or incorrect information to be corrected, please submit this action before submitting an appeal.
- Provider relevant supporting documentation, including but not limited to: copy of claim, explanation of payment, medical records, and previous related correspondence. If sufficient information in not included, an appeal review may be delayed on not conducted.

Date: 05/04/2023	Type of Appeal: Claim ■ Authorization ☐

Provider/Group/Facility Information

Provider/Group/Facility Name: Boulder Medical Center	
Provider TIN/NPI Number: 840834835/1306820923	
Contact Name: Shole	
Phone Number: 3034403005	**Fax Number:** 3034403294
Email Address: safsar@bouldermedicalcenter.com	
Address: 2750 Broadway, Boulder CO	**Apt./Suite:**
City: Boulder	**State:** CO **Zip Code:** 80304

Member Information

Last Name: Iarragoitiy	**First Name:** Elizabeth
DOB: 07/05/1963	**Member ID Number:** 200421931-01
Address: 406 e chester st #B Lafayette, CO80026	**Phone Number:** 2103814820

Claim Information

Provider	**Facility**	**Ancillary Health Care Professional (DME, lab, ect.)**
Claim #: 20230217003403	**Authorization # (if applicable)** Issue 2325217	**DOS:** 11/02/2022
Billed Amount: $205	**Paid Amount:** $0	

State reason for Appeal:

Patient notified us with correct ID#200421931-01 on 2/28/23 with effective date 11/1/2022
When I was searching for claim information for DOS 1/16/2023 amount $205 on FHP web on 2/16/2023, noticed that DOS 11/02/2022 was not submitted to 200421931-01 so as a courtesy to our patient I billed this claim to the current ID number that patient provided on 2/28/23 to us.
I'm requesting in this 2nd appeal, please reprocess this claim and apply the balance due to the patient responsibility as a courtesy to provider.

Submission Options: Fax, email, mail

Fax: 844-280-1794, *please do not fax more than 100 pages at one time, split into multiple faxes or submit another way.*
Email: appeals@fridayhealthplans.com
Mail: Attn: Appeals Dept., 700 Main St., Suite 100, Alamosa, CO 81101