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: 05/02/2023	Type of Appeal: Claim [redacted] Authorization [redacted]

Provider/Group/Facility Information

Provider/Group/Facility Name: Boulder Medical Center/ Boulder comm Hosp FH OP/ Dr. ROG		
Provider TIN/NPI Number: 840834835/1306820923/1679863112		
Contact Name: Shole Afsar		
Phone Number: 3034403005	**Fax Number:** 3034403294	
Email Address: safsar@bouldermedicalcenter.com		
Address: 2750 Broadway		**Apt./Suite:**
City: Boulder	**State:** CO	**Zip Code:** 80304

Member Information

Last Name: Grove	**First Name:** George	
DOB: 01/23/1972	**Member ID Number:** 200121388-01	
Address: 2330 Balsam Dr Boulder, CO 80304	**Phone Number:** 5044327093	

Claim Information

Provider x	**Facility** x	**Ancillary Health Care Professional (DME, lab, ect.)**	
Claim #: 20230104007248	**Authorization # (if applicable)** ER no need for Auth.	**DOS:** 12/21/2022	
Billed Amount: $5428	**Paid Amount:** $0		

State reason for Appeal:

This patient came through the ER on 12/21/22 at 4:08pm then went to OR at 10:55 am
Discharged on 12/22/22 at 2:25 pm so within hours he left the hospital.
please allow All lines, outpatient ER hospital with only few hours stay SHOULD not need An Authorization

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