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: 04/04/2023	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 A.	
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: Pokryfke	**First Name:** Keith
DOB: 10/13/1967	**Member ID Number:** 200063521-01
Address: 1057 W 112th Ave. #A westminster,CO 802	**Phone Number:** 3037464632

Claim Information

Provider x	**Facility**	**Ancillary Health Care Professional (DME, lab, ect.)**
Claim #: 20230110006071	**Authorization # (if applicable)**	**DOS:** 01/05/2023
Billed Amount: $894.45	**Paid Amount:** $197.48	

State reason for Appeal:

line 2- to Line 4 are CPT for Immunization they all have PRIM diag. Z23 Should not be Deducible amount per attached medical records all medically necessary and must be allowed and paid
line 4- 90677 $404.67 this was recommended by provider as medically necessary per attachment.
Originally claim processed incorrectly because of FHP IT configuration issues.

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