

## 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 is not included, an appeal review may be delayed or not conducted.

Date: 06/07/2023    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 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:** Leonardo

**First Name:** Maxine

**DOB:** 03/07/2023

**Member ID Number:** 200488593-03

**Address:** 6754 Yarrow st Arvada, CO 80004

**Phone Number:** 7206439281

### Claim Information

**Provider** ☒

**Facility**

**Ancillary Health Care Professional (DME, lab, ect.)**

**Claim #:** 20230418003185

**Authorization # (if applicable)**  
N/A

**DOS:** 03/08/2023

**Billed Amount:** \$402

**Paid Amount:** \$0

State reason for Appeal:

Boulder Medical center billed for provider's charges, and newborn stayed in the hospital, getting an Authorization must not be provider's responsibility, this should not be a requirement for the provider only for the hospital which patient stayed for few days. Therefore please allow provider's charges since provider doesn't have responsibility of getting authorization for hospital staying.

### 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](mailto:appeals@fridayhealthplans.com)

Mail: Attn: Appeals Dept., 700 Main St., Suite 100, Alamosa, CO 81101