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: 03/28/2023	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: GOLDMAN	**First Name:** MEGAN	
DOB: 04/19/1990	**Member ID Number:** 200440175-01	
Address: 3145 Arnett st #203 Boulder, CO 80304	**Phone Number:** 3038774856	

Claim Information

Provider X	**Facility**	**Ancillary Health Care Professional (DME, lab, ect.)**	
Claim #: 20230314003727	**Authorization # (if applicable)**		**DOS:** 02/21/2023
Billed Amount: $4557		**Paid Amount:** $0	

State reason for Appeal:

This is Global C-SECTION, per OP-NOTES MEDICALLY NECESSARY, must be allowed witout NO AUTH.

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