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800-475-8466

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: 4/3/23	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: 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	**Facility**	**Ancillary Health Care Professional (DME, lab, ect.)**	
Claim #: 20230104007248	**Authorization # (if applicable)**		**DOS:** 12/21/2022
Billed Amount: $5428		**Paid Amount:** $0	

State reason for Appeal:

outpatient hospital Should not need Authorization, Please see attachment for OP- NOTES

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