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: 3/9/23	Type of Appeal: Claim ■ Authorization ☐

Provider/Group/Facility Information

Provider/Group/Facility Name: Boulder Medical Center		
Provider TIN/NPI Number: 840 834 835/ 1306820923		
Contact Name: Shole Afsar		
Phone Number: 303 440 3005	**Fax Number:** 303 440 3294	
Email Address: safsar@bouldermedicalcenter.com		
Address: 2750 Broadway	**Apt./Suite:**	
City: Boulder	**State:** CO	**Zip Code:** 80304

Member Information

Last Name: Joffe	**First Name:** Stephen	
DOB: 07/07/1966	**Member ID Number:** 20008798802	
Address: 4770 14th st Boulder CO 80304	**Phone Number:** 720 933 6011	

Claim Information

Provider x	**Facility**	**Ancillary Health Care Professional (DME, lab, ect.)**	
Claim #: 20221220014119	**Authorization # (if applicable)**	**DOS:** 08/10/2022	
Billed Amount: $399	**Paid Amount:** $0		

State reason for Appeal:

This claim is replacement or corrected claim to claim#20220826009283 amount $507. The reason for that as a profesional courtesy to our member we decided to use CPT 99203 instead of 99204, since he called us on 12/13/22 and requested, if there is anything else we can do for him? the balance due amount $447.78 it's more than he was expected from this visit, according to the original claim fee $507 #20220826009283. On that day was the 1st time he saw the bill eventhough we have sent him 4 statements before December, please requestingasaprofesionalcourtesyallow99203

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