Prestige
HEALTH CHOICE®
Leading the Way to Quality Care

Provider Appeal Form

This form will help ensure that your appeal is processed as efficiently and effectively as possible. Please fill out the form completely and mail to:

Prestige Health Choice, Attn: Provider Appeals, P.O. Box 7366, London, KY 40742
Fax: 1-855-358-5853

Member information:	
Name:	Medicaid ID:

Provider information:	
Name:	Medicaid ID:
Taxpayer identification number (TIN):	National Provider Identifier (NPI):

Submitter contact information:	
Name:	Phone number:
Fax number:	Address:

Claim information: **(For multiple claims, please list on a separate page.)**	
Claim number:	Date of service:
Billed amount:	Remittance advice date*:

*Appeals must be received within 180 days of the remittance advice date to be considered for review.

Please select the reason for your appeal:

- ☐ Service is not a duplicate (please provide details below)
- ☐ Claim denied for timely filing — proof enclosed
- ☐ Claim denied due to a clinical and/or coding edit
- ☐ Claim denied for no allowable
- ☐ Claim denied for no authorization — authorization # ____________________ was obtained
- ☐ Claim denied for no authorization — authorization was not obtained; medical records enclosed (**300 page limit**)
- ☐ Claim is underpaid — expected payment amount is: $_______________

  Please provide details and/or calculation of expected payment amount (include copy of contract if applicable.)
- ☐ Other: ____

____

If a claim was denied for failure to attach one of the following items, please submit a new claim directly to the Claims department with the requested information.

☐ Primary Explanation of Benefits ☐ Medical records ☐ Itemized bill ☐ Sterilization/consent form

This is not an appeal and should not be sent to the Provider Appeals department.

P2349_1805