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Claim Appeal Form

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal.
Note: This form is NOT required for the submission of Appeals but recomended for a quicker response time.

Provider Name	Provider Tax ID
Provider NPI	Ùcæ^Á¸ @¦^Á§{ æ^Á•Á@˘•^å
Centurion Claim Number	Dates of Service
Q{ æ^ Name	Q{ æ^ ID

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

Claim was denied for no authorization, but authorization number ______________________ was obtained.
Claim was denied for no authorization, but no authorization is required for this service.
Claim was denied for Medicaid responsiblity in error.
Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
Claim was not paid per the terms of my contract with Centurion HealthPlan (attach relevant reimbursement section).
Claim was denied "Past Timely Filing" (attach proof of timely filing).

- *Note: If the past timely filing deadline denial falls on a weekend or holiday, the provider may request a reconsideration .*

Claim was paid the incorrect amount (include calculation of expected payment and supporting information)
Claim denied based on

- *Note: Payment policies can be found at* *https://www.centurionmanagedcare.com/for-providers/provider-resources.html*

Other. Please explain (and provide supporting documentation):
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Please ensure sufficient detail is provided to assist us in the review of your appeal.

Mail completed forms and all attachments to:
7 Ybh f]cb HealthPlan
Claims 5 ddYU g Department
PO BOX ($- $
Farmington, Missouri 63640-3800

Contact name & number of person requesting the appeal: ____

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