CLAIM ADJUSTMENT OR APPEAL REQUEST FORM

NOTE: Appeals and adjustments must be submitted within ninety (90) days of receipt of payment or denial. One form per claim.

For ***all*** **iCircle members** send to:

iCircle
ATTN: Claims Appeals
860 Hard Road
Webster, NY 14580
Or fax this form to: 844.327.5551

PROVIDER INFORMATION:

Practitioner Name: Tax Identification Number (TIN):

Facility/Group Name: National Provider Number (NPI):

CONTACT INFORMATION:
Requester: Phone Number: Fax Number: Date:

CLAIM INFORMATION:

Member (Patient) Name: Authorization Number:

Date of Birth: Service Type:

Member ID Number: Date(s) of Service:

Claim Number: Denial / Reason Code(s):

REASON FOR REQUEST:

- ☐ Timely Filing – claims submitted beyond 120 days from DOS.
- ☐ Pricing – Incorrect payment or application of benefits
- ☐ Eligibility – Payment issues for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- ☐ Medical Review–Request a determination of medical necessity or a denial for failure to obtain prior authorization. Supporting documentation is required.
- ☐ Code Review – Request of coding decision; supporting documentation required
- ☐ Other -

SUPPLEMENTAL DOCUMENTATION ATTACHED:

- ☐ Remittance Advice ☐ Refund ☐ Medical Records
- ☐ Copy of Claim
- ☐ Other (e.g. timely filing documentation such as practice management notes)

After you've received a response for your initial request and if you still do not agree, you may appeal by adding your rationale below and attach supporting documentation. Please submit to the appropriate address above.

TOTAL NUMBER OF PAGES:

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