

## Appeal Request

Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Address: \_\_\_\_\_  
\_\_\_\_\_

Provider Federal TIN: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Provider Email: \_\_\_\_\_

Provider Contact Name: \_\_\_\_\_

Claim #: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Participant Client Number: \_\_\_\_\_

Participant Date of Birth: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Service Performed: \_\_\_\_\_

Reason for Appeal:

Signature: \_\_\_\_\_

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### RMHCS ONLY:

Appeal Determination: \_\_\_\_\_

Date: \_\_\_\_\_