



Provider Appeal Request Form Instructions:

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing DESCRIPTION OF APPEAL and EXPECTED OUTCOME.
- Provide additional information to support the description of the Appeal. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: MARCH Vision Care, 6601 Center Drive West, Suite 200, Los Angeles, CA 90045
- This form only applies to the State of Kansas

Provider Name*:	Provider Tax ID #/Medicare ID #*:
Provider Address:	

Provider Type: MD Mental Health Professional Mental Health Institutional Hospital ASC
 SNF DME Rehab Home Health Ambulance Other (please specify):

Claim Information Single Multiple "Like" Claims (Complete attached spreadsheet) **Number of claims:**

Patient Name*:		Date of Birth:	
Health Plan ID Number*:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)	
Service "From/To" Date*: (Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:	
A Type: <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment		<input type="checkbox"/> Seeking Resolution of a Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Other:	
Description of Appeal:			
Expected Outcome:			

Contact Name (Please Print)	Title	() _____ Phone Number
Signature	Date	() _____ Fax Number

[] Check here if additional information is attached. Please do not staple.

For MARCH use only.	
Tracking Number:	Provider ID:
Contracted:	Non-Contracted:



Provider Appeal Resolution Request Form

(For use with multiple "like" claims)

Number	Patient Name Last	First	Date of Birth	Health Plan ID Number	Original Claim ID Number	Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Page ___ of ___

Check here if additional information is attached. Please do not staple.