



Today's Date: _____

Provider Administrative Appeal

(Not to be used for initial claim submission or claim adjustments/corrections)

Please complete this form in its entirety. The information needed to consider your appeal is outlined in the documentation checklist for administrative appeals in the *BMC HealthNet Plan Provider Manual*.

Submission Requirements:

- Appeals must be submitted within 150 days from the original date of denial and no later than 300 days from the date of service; appeals submitted after this time frame will be denied.
- Please provide a separate appeal form for each date of service.
- All incomplete appeal submissions will be rejected and returned.

Provider Name: _____ NPI #: _____ TAX ID #: _____	Contact Name: _____ Telephone #: _____ Address to Send Response: _____
Provide the following information from your remittance advice (RA):	
Member Name: _____ Claim Number: _____ Patient Account #: _____	Member ID #: _____ Date of Service: _____ RA Denial Code: _____

Reason for Appeal:

<input type="checkbox"/> Failure to submit within filing limit	<input type="checkbox"/> Member Ineligible	<input type="checkbox"/> Benefit Restrictions
<input type="checkbox"/> Lack of Prior authorization	<input type="checkbox"/> Clinical Editing	
List code(s) or service(s) being appealed: _____ _____		
Supporting rationale for appeal: _____ _____		

If you have a question about an administrative appeal, you may call the provider line at 1-888-566-0008 and select the claims option; you will be directed to the Claims Resolution Unit.

Please mail this *Administrative Appeal Request Form* and all supporting documentation to:

BMC HealthNet Plan
 Claims Resolution Unit
 Attention: Appeals Department
 P.O. Box 55282
 Boston, MA 02205