MUNICIPAL HEALTH APPEAL FORM

Appeal requests must be completed on this Provider Appeal Form. The Request must include Municipal Health member number, date(s) of service, claim number(s), reason for the appeal, and other relevant information regarding the appeal. Municipal Health's Claims Review Team will review the appeal and notify the provider via mail of the appeal decision within 60 days of receipt of the appeal.

Appeals may be submitted by mail: **MUNICIPAL HEALTH**
PO BOX 188
NORTH LITTLE ROCK, AR. 72115

Appeal Submission Date: _____

SUBMISSION INFORMATION

Please check the issue that best describes the reason for your appeal.
The initial decisions were related to:

- ☐ Benefit plan exclusion or limitation
- ☐ Coordination of Benefits (COB) related issues
- ☐ No Surprise Act related charges or claims
- ☐ Precertification or prior authorization not obtained
- ☐ Timely filling of claim
- ☐ Your Municipal Health contract, fee schedule, or reimbursement terms
- ☒ Other, please explain:

MEMBER INFORMATION:

Municipal Health Subscriber Name: _____

Municipal Health Subscriber ID Number: _____

Patient Name: _____ Date of Birth: _____

Date of Service: _____ to _____ Claim number, if applicable: _____

PROVIDER INFORMATION:

Provider Name: _____

NPI Number: _____

Return Address: _____ Phone Number: _____

Contact Person: _____

Appeal Explanation (Please provide a clear explanation of the reason for your appeal).

Appeal determination **(Municipal Health use only)**. Group: _____

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