

PROVIDER CLAIM APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant myNEXUS to re-evaluate its original decision.

- An appeal request must include claim numbers and supporting documentation (e.g. complete copy of the medical records and claim form).
- Review of a claim does not guarantee a change in payment disposition.
- An acknowledgement letter will be sent to you within ten (10) calendar days upon receipt of the Appeal Form.

Provider Information:

Provider Name: _____

Provider NPI #: _____

Claim Information:

Member Name: _____ Claim Number(s): _____

Member Group & ID #: _____ Date(s) of Service: _____

Reason for Appeal:

- Timely Filing – Claims with DOS submitted beyond the allowed days as outlined within providers contractual agreement
- Pricing – Incorrect payment or application of benefits
- Eligibility – Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- Medical Policy – Appeal a denial for failure to obtain prior authorization (Supporting documentation required).
- Other – Provide a detailed description

Description of Claim Appeal:

Supplemental Documentation Attached:

Remittance Advice Refund Medical Records Other (e.g. Timely filing Documentation)

Contact Information:

Requester: _____ Phone #: _____ Date: _____

Mail completed form and attachments to:

myNexus, Inc.
Attention: Provider Claim Appeals
P.O. Box 991
Brentwood, TN 37024

-OR-

Email completed form and attachments to:

claimappeals@mynexuscare.com

Attention: Claim Appeal