myNEXUS

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 the myNEXUS claim numbers and supporting documentation (e.g. complete copy of the medical records and claim appeal request form).
- Unless otherwise stated in your agreement, initial appeal must be submitted within 90 days claim denial date; 2nd level appeal must be submitted within 30 days of 1st appeal denial.
- Complete one request form for each patient you are submitting for the appeal.
- 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:

- ☐ Clerical Error – Not a true duplicate, incorrect or missing modifier, incorrect billed quantity, incorrect bill amount
- ☐ 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: _____

Email Address: _____

Please submit the completed form and attachments via secure email to:

claimappeals@myNEXUScare.com