

## Post service and 2nd level appeal request form

If you are a member submitting an appeal, please complete the information below and include any additional medical records or documentation to support your appeal. If you have a copy of the claim or the Explanation of Benefits (EOB) please include a copy with your submission. If you are a provider submitting a claim on behalf of a member, please include a copy of the EOB, a copy of the claim and any/all medical records and/or documentation to support your request for the appeal.

**Please complete the following information:**

Appeal is being filed by: Member \_\_\_ Physician \_\_\_ Facility \_\_\_ Other representative \_\_\_

If other representative is selected, please indicate relationship to member and include a signed personal representative form or your appeal will be returned:

<i>Today's date</i>		<i>Group name</i>		
<i>Member's first name</i>		<i>Member's last name</i>		<i>Member's ID number</i>
<i>Address of Member</i>				
<i>Patient's first name</i>		<i>Patient's last name</i>		<i>Patient's date of birth</i>
<i>Name of provider</i>		<i>Provider's TIN/NPI</i>		<i>Provider's phone number</i>
<i>Address of provider</i>				
<i>Claim number</i>		<i>Claim date of service</i>		
<i>CPT/HCPCS/Service being disputed</i>				
<i>Explanation of your request (please submit additional pages if necessary)</i>				

Please fax or email your *post-service* appeal or 2<sup>nd</sup> level appeal with this form to: 586-238-4363 or [appeal\\_fax@ascension.org](mailto:appeal_fax@ascension.org).

You may also mail your post service appeal to: Appeals Department, PO Box 321125, Detroit MI 48232.