CLAIM APPEAL FORM

Use this form as part of the Magnolia Health Plan of Mississippi Claim Appeal process to dispute an adverse benefit determination. The Claim Appeal Form must be attached to the Claim Appeal. The Claim Appeal process should only be followed if you are dissatisfied with the outcome of a Claim Reconsideration.

NOTE: The Claim Appeal should be filed within thirty (30) calendar days of the date on Magnolia's notice of Adverse Benefit Determination.

All fields in the box immediately below are required information

Provider Name	Provider Tax ID#
Control Number *Located EOP Under Patient Name*	Date(s) of Service
Member Name	Member (RID) Number

Reason for Claim Appeal (please check):

☐ Claim was denied for no authorization, but authorization #_________________ was obtained.
☐ Claim was denied for no authorization, but no authorization is required for this service.
☐ Claim was denied for untimely filing in error (proof of timely filing should be attached).
☐ Claim was paid to wrong provider
☐ Claim was paid for incorrect amount
☐ Other (please explain below) ____

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Date of Request:______________________ Requestor Name: ______________________________

Requestor Phone Number:____

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled. .

NOTE: If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the provider manual. Please do not include this form with a corrected claim.

Mail completed form(s) and attachments to:

Magnolia Health Plan
PO Box 3090
Farmington, MO 63640-3800

Important Notice: Magnolia Health Plan will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you an EOP or letter to that effect.

(This form may be photocopied)