DO NOT USE THIS FORM FOR A RECONSIDERATION REQUEST. USE THE "RECONSIDERATION REQUEST FORM".

Claim Appeal Form

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
Magnolia Claim Number*	Dates of Service*
Member Name*	Member ID*

***Required fields**

If your appeal involves more than one claim number, DOS, member name, or member ID for the same appeal reason, this information must be included as an attachment to this form.

Reason for the appeal:

- ☐ Claim was denied for no authorization, but authorization number _____was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for no authorization, however authorization was not obtained because _____
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Magnolia Health (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information)
- ☐ Claim denied based on Magnolia Health's payment policy (attach medical records to support services provided).
    - *Note: Payment policies can be found at https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html*

_____

_____

_____

☐ Other. Please explain (and provide supporting documentation):

_____

A Claim Appeal may be submitted in 3 ways: mail, fax, or via secure web portal.

Mail to:	**Fax to:**	**Secure web portal:**
ATTN: Claim Appeal **PO BOX 3090** **Farmington, Missouri 63640-3800**	**833-950-3857**	**https://www.magnoliahealthplan.com/login.html**

Please ensure sufficient detail is provided to assist us in the review of your appeal.

Contact name & number of requestor: _____

Request Date:_____