

APPEAL FORM



Mail completed form to: MHS Health Appeals Department P.O. Box 3000 Farmington, MO 63640-3800

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|---|-------------------------------------|
| <i>Name/Address of Person Submitting Appeal</i> | <i>Date this form is being sent</i> |
| <i>Provider Name</i> | <i>MHS Provider Number</i> |
| <i>Claim Control Number</i> | <i>Date(s) of Service</i> |
| <i>Member Name</i> | <i>Member Number</i> |

Reason for appeal:

- ☐ Other insurance payment (Explanation of Benefits [EOB]; Explanation of Processing [EOP] must be attached)
- ☐ Incorrect payment or other (please explain **in detail** below):

- ☐ Correct following detail on previously processed claim
- ☐ Add following information to previously processed claim

| <i>DOS From</i> | <i>DOS To</i> | <i>POS</i> | <i>TOS</i> | <i>Proc/Rev Code</i> | <i>Mod (1)</i> | <i>Mod (2)</i> | <i>Billed Amt</i> | <i>Unit</i> | <i>EPSDT</i> | <i>EMG</i> | <i>MHS Servicing Provider #</i> |
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For MHS Internal Use Only:

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| Date Recv'd: | Date Due: | Reviewed By: |
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8/2015