APPEAL FORM

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

Name/Address of Person Submitting Appeal	*Date this form is being sent*
Provider Name	*MHS Provider Number*
Claim Control Number	*Date(s) of Service*
Member Name	*Member Number*

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

DOS From	*DOS To*	*POS*	*TOS*	*Proc/Rev Code*	*Mod (1)*	*Mod (2)*	*Billed Amt*	*Unit*	*EPSDT*	*EMG*	*MHS Servicing Provider #*

For MHS Internal Use Only:

Date Recv'd:	Date Due:	Reviewed By:

8/2015