Coding Denial Appeal Form

Requests received without the required information will not be reviewed

I. PROVIDER CONTACT INFORMATION

Provider Name: Date:

Contact Name: Provider Number:

Phone: Email:

( ) ___________________________ Ext.

Fax:

( ) ___________________________

I. MEMBER INFORMATION

Member Name: Patient Account:

Claim Number: Member Number:

Date of Service:

☐ INCORRECT CODING REVIEW  Claims that have been returned for incorrect coding (e.g. bundling, inappropriate modifier, invalid diagnosis / CPT code). Please provide reason you believe the claim has been coded correctly below (stating that claim is coded correctly is not enough information for review):

☐ CODING DENIAL RECONSIDERATION REQUEST  An appeal will be considered when the provider sends medical records accompanied by this form and / or letter explaining what the appeal / reconsideration is in detail. Medical records alone will be placed into Member’s record until written explanation of issue to be reviewed is received. Please provide explanation below:

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Please send form to:
Quartz, Attn: CIU Department, 840 Carolina Street, Sauk City, WI 53583 or fax to (608) 643-2564

PLEASE FOLLOW MINIMUM NECESSARY WHEN TRANSMITTING MEDICAL RECORDS TO KEEP OUR MEMBER’S INFORMATION SECURE

QA00939 (0519)