



PROVIDER APPEAL FORM

PO Box 24087 Nashville, TN 37202

FAX: 800-931-0149

*NOTICE – If you are submitting either a corrected claim or additional information as requested to process your claim do **NOT** use this form. Submit corrected claims/additional requested information to HealthSpring of Alabama, PO Box 20000, Nashville TN 37202. This form is for use in appealing denied claims/services ONLY.

☐ Commercial

☐ Medicare

☐ Par

☐ Non-Par

Member Name _____

Member # _____

Provider of Svc. _____

Provider # _____

Appellant _____

Appellant's

Appellant's
Address _____

Phone # _____

Attn: _____ City _____ St _____ Zip _____

Claim # (Listed as control on remit)	Date(s) of Service	Claim Amount (Located on remit)
		\$
		\$
		\$
		\$

(Providers, please fill out the above information completely and give a full explanation of appeal below.)

EXPLANATION OF APPEAL:

Signature / Date:

>>> Providers, Please Do Not Write Below This Section <<<

Date Received SU

Type of Appeal:

Inquiry #

Appeal Record #