United Food and Commercial Workers Union Local 1529
And Employers Health and Welfare Plan and Trust

ADMINISTRATIVE OFFICE

Administrative Consulting Services of Tennessee
661 N. Ericson Rd. Cordova, TN 38018
Telephone (901)758-3000
Toll Free (800) 874-8499

APPEAL REQUEST FORM

Instructions:

1.) Complete this form
2.) Include a copy of the original claim, explanation of benefit and any documentation to support your appeal. Please note we do not pay for any records submitted to this office.
3.) Mail to the Administrative Office

Appeals should be submitted within 180 days, of the adverse determination was made.

Who is filing appeal (Select One below):

□Physician □Hospital □Other health care professional (Lab, Durable Medical Equipment (DME), etc) Date Form Completed: ___/___/_____

Is this a second appeal ? __Yes ___No. No new claims should be submitted with this form. Please submit a separate form for each claim.

Member Information

Member ID:	Claim#:	Date of Service:	Billed Amount:
Member Name : Last	First		MI
Street Address	State		Zip
Patient Name : Last	First		MI

Physician/health care professional information

Tax Identification Number (TIN):	Phone Number: ( )	Email Address:
Physician Name (as listed on Explanation of Benefits) Last	First	MI
Street Address	State	Zip
Facility/Group Name	Contact Person:	
Option amount Owed:		

Reason for Appeal (select one or more)

☐ 1. Previously denied/closed as "Exceeds Filing Time" What should I submit as evidence of timely filing? ---
- Electronic Claims – include confirmation that UFCW 1529 or one of the affiliates received and accepted your claim.
- Paper claims –include copy of a screen print from your accounting software to show the date you submitted the claim.
- The accounting software information must also include proof that the claim is for the correct patient and the correct visit.
- *Proof of timely filing could also include other insurance carrier's denial/rejections, EOB, letter indicating terminated coverage, not a plan participant, etc.

☐ 2 .Previously denied/closed for "Additional Information" (provide description and/or requested documents)

☐ 3. Previously denied/closed for "Consideration of Benefits" information (attach primary carrier's Explanation of Benefits)

☐ 4. Resubmission of a correct claim (explain correction below)

☐ 5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment (explain below)

☐ 6. Resubmission of "Prior Notification Information" (including notification information)

☐ 7. Resubmission of "Bundled Claim" (include all supporting information)

☐ 8. Coverage Exclusion or Limitation

☐ 9.Request for in-network coverage

☐ 10. Inpatient Facility Denial (Level of Care, Length of Stay)

☐ 11. Benefits reduced due to re-pricing of billed procedures

Please include what you are expecting from United Food and Commercial Workers Union Local 1529 Health and Welfare Plan and Trust to close United Food and Commercial Workers Union Local 1529 Health and Welfare Plan and Trust's portion of this claim in your practice management system, including dollar amount if possible