Appeal Request Form

This form is to be used when a patient is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.

Insurance company name and address

☐ 1st Appeal ☐ 2nd Appeal ☐ 3rd Appeal

Clinic/Hospital/Provider Information:

Name: Mayo Clinic

Address:

Patient Account Number:

Claim Information:

Patient Name:

Insurance ID Number:

Date(s) of Service:

Insurance Claim Number (on your EOB)**:**

Reason for Appeal Request:

☐ Pre-certification/authorization ☐ Medical Necessity/experimental/investigational ☐ Non-covered
☐ Out of Network ☐ Usual Customary and Reasonable ☐ Other

Provide a brief description of reason for claim appeal.

Supplemental Documentation:

☐ Explanation of Benefits ☐ Medical Records ☐ Other (describe):

Contact Information:

Patient/insured:
Individual requesting appeal

Date:
Date of appeal request

Contact Number:
Phone, fax or email should be supplied

Address:

Mailing address for response

Total number of pages: