SmartHealth®

Post service and 2nd level appeal request form

If you are a member submitting an appeal, please complete the information below and include any additional medical records or documentation to support your appeal. If you have a copy of the claim or the Explanation of Benefits (EOB) please include a copy with your submission. If you are a provider submitting a claim on behalf of a member, please include a copy of the EOB, a copy of the claim and any/all medical records and/or documentation to support your request for the appeal.

Please complete the following information:

Appeal is being filed by: Member ___ Physician ___ Facility ___ Other representative ___

If other representative is selected, please indicate relationship to member:

Today's date	*Group name*	
Member's first name	*Member's last name*	*Member's ID number*
Patient's first name	*Patient's last name*	*Patient's date of birth*
Name of provider	*Provider's TIN/NPI*	*Provider's phone number*
Claim number	*Claim date of service*	
CPT/HCPCS/Service being disputed		
Explanation of your request (please submit additional pages if necessary)		

Please fax your *post-service* appeal or 2nd level appeal with this form to: 586-238-4363.
You may also mail your post service appeal to: Appeals Department, PO Box 321125, Detroit MI 48232.

Ascension