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 and include a signed personal representative form or your appeal will be returned:

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

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

Ascension