



PROVIDER APPEAL FORM
One appeal per form please
 This appeal should apply only to one member

Today's date: _____ Contracting Provider #: _____ Provider name: _____
 (Business name)

Your name: _____ Your phone: (____) _____ Address: _____

First Plan member's ID number	Patient name	Claim Number If your appeal includes more than one claim, attach a list of the claims impacted.
Group #	Billed charge	Service date(s)

Appeal request	<p>Your appeal request pertains to (check one)</p> <p><input type="checkbox"/> Surgical Complications (Modifier 22): include chart notes, operative reports, letter stating rationale for complication</p> <p><input type="checkbox"/> Medical Necessity: include medical records and rationale for service performed</p> <p><input type="checkbox"/> Investigative: include medical records and rationale for service performed</p> <p><input type="checkbox"/> Claim Denied for no PA: include medical records and rationale for service</p> <p><input type="checkbox"/> DRG/Category Code: include rationale for questioning of payment</p> <p><input type="checkbox"/> Private Room: include notes, doctor's order and letter of medical necessity</p> <p><input type="checkbox"/> Allowed Amount: include chart notes or invoice, NDC number and a letter to review allowance for an unlisted code</p> <p><input type="checkbox"/> Incompatible Diagnosis: include letter requesting review of codes that are denying as incompatible and related notes</p> <p><input type="checkbox"/> Timely Filing (specify A – H from key on back): include some or all of the following: your computer screen prints showing activity, other payer remits or denials, copies of letters sent to our member, collection agency documents, documentation of follow up with Provider Crossroads and Provider Service, proof of other payer timely filing rules, detailed description of vendors or system issues, claim volume and dollar impact of issues</p> <p><input type="checkbox"/> Other _____: include supporting documentation for your appeal.</p>
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Mail to	<p>Please note this must be mailed to:</p> <p>First Plan of Minnesota Attn: Health Management 525 South Lake Avenue, Suite 222 Duluth, Minnesota 55802</p>
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CHECK HERE if multiple related appeals are being submitted. Specify number in of format (e.g., 1 of 5, or 3 of 10). This type of request still requires one form per member.

First Plan of Minnesota Provider Appeal Form Instructions

The Provider Appeal Form is designed for providers to submit their appeals to First Plan of Minnesota. The general instructions are listed below. Please submit only one appeal per page and mail with appropriate attachments to First Plan. All fields must be completed.

Field		Description
Today's date		Date you are submitting the appeal.
Contracting provider #		Your First Plan contracting provider number.
Provider name		Contracting provider business name.
Your name		Name of the person we are to respond to.
Your phone		Phone number of the contact person at your office.
Address		Address of provider's office.
Member ID#		First Plan member's ID number. Make sure to include any appropriate alpha prefix.
Patient name		Patient's name. It may be different than the member's name.
Claim Number		Claim number, if your appeal includes more than one claim attach a list of the claims impacted.
Group #		The account/group number as it appears on the ID card.
Billed charge		Total billed charge. Not just the amount left to pay if another carrier paid primary.
Service date(s)		All date(s) of service for the claim in question.
Appeal request	Your appeal request (check one)	When requesting an appeal, check the reason for the appeal and include detailed information when necessary.
	Surgical Complications	Include chart notes, operative report and a letter from the doctor stating rationale for complication.
	Medical Necessity	Include medical records and rationale for service that was performed.
	Investigative	Include medical records and rationale for service that was performed.
	Claim Denied for no PA:	Include medical records and rationale for service that was performed.
	DRG/Category Code	Include rationale for questioning payment.
	Private Room	Include notes, doctor's order, and letter of medical necessity.
	Allowed Amount	Include chart notes or invoice, NDC number and letter to review the allowance for an unlisted code.
	Incompatible Diagnosis	Include letter requesting a review of codes that are denying as incompatible and related notes.
	Timely Filing (specify scenario A – H on front)	A: Patient did not inform provider they had First Plan coverage B: Provider submitted claim, payer has no record C: Provider vendor or system related issue prevented timely filing D: Claims discovered as result of merger at provider's office E: Claims discovered as result of accounts receivable clean-up effort F: Subrogation related issue prevented timely filing G: Claim denied as outside member's contract timely filing but within our timely filing H: Member gave incorrect demographic or insurance information to provider NOTE: If a Medicare Crossover or Coordination of Benefit issue prevented timely filing please submit a Provider Inquiry Form ALSO NOTE: Denials for timely filing of BlueCard claims must be submitted to the patient's Home Plan
Other	Include supporting documentation for your appeal.	
Check Box	Check box, enter numbers	If multiple related appeals are being submitted together, check the box and indicate the number in a 1 of 5 or 3 of 10 format.