Non-Participating Provider Claim Appeal Form

Section 1: Provider Information			
Date of Appeal (MM/DD/YYYY)	Provider Name		
National Provider Identifier (NPI)	Tax ID Number:	Leon Health Provider ID:	
Street Address	City	State	Zip-Code
Telephone Number	Fax Number		
E-mail Address:	Contact Name		

Section 2: Leon Health Member Information	
Full Name (First, Middle, Last)	Member ID or Medicare Number
Date of Birth	

Section 3: Claim Information	
Claim #	Dates of Service (MM/DD/YYYY) (From) (To)
Total Billed Amount	Date of Initial Determination Notice (e.g., Integrated Denial Notice, Remittance Advice) (MM/DD/YYYY)
Services/Items Under Appeal Procedure Code(s) ICD-10 Code(s)	

Section 3: Appeal Information

To facilitate the review of your request, at a minimum, please include the following documents with your appeal request:

- ❑ Waiver of Liability (WOL) (Your request will not be reviewed until you provide a properly executed WOL.)
- ❑ Copy of remittance advice and/or Notice of Denial of Payment

When applicable, please include the following documents as well:

- ❑ Pertinent medical records
  - ❑ Ambulance run sheet
  - ❑ History and physical
  - ❑ Invoices for unlisted procedures and medication
  - ❑ Diagnostic test results
  - ❑ Pathology reports
  - ❑ Progress notes
  - ❑ Other medical records
- ❑ Copy of Authorization or Referral
- ❑ Other: _____
- ❑ Proof of Timely Filling

*If more than 60 calendar days have elapsed since you received the initial determination notice, provide a reason why you are filing late

**Reason for the Appeal (Attach an additional sheet if additional space is needed.)

*** If Leon Health, Inc. receives your appeal request after 60 days from the date on which you received the initial determination notice, your request will be dismissed unless you can provide good cause for filing late.**

**** If you are submitting medical records for a claim that was denied because the Plan requested medical records and they were not provided within the required timeframe, or you are disputing a claim denial because you believe it was improperly denied due to a clerical error (including minor errors and omissions), in accordance with 42 C.F.R § 405.980, the request will be handled as a reopening request rather than an appeal.**

Submit your completed appeal form and supporting documentation to:

Mail **Grievance & Appeals Department**
Leon Health, Inc.
P.O. Box 668230
Miami, FL 33166

Fax **305-718-2862**