PerformCARE®
P.O. Box 7301
London, KY 40742

ADMINISTRATIVE APPEAL REQUEST

Date: _____

Member Information

Member name: _____

County of residence: _____ MAID number: _____

Primary insurance: _____ Secondary insurance: _____

Provider Information

Provider name: _____

Provider site address: _____

Contact person's name: _____

Contact person's address: _____

Phone number: _____

Appeal Information

Date(s) of service to be reviewed: _____

Type of service: _____ CPT code: _____ Modifier: _____

Authorization number: _____ Claim number: _____

Total dollar amount requested: _____

Provider's requested action:

_____

_____

Reason for denial:

_____

_____

Steps taken to correct and prevent future occurrences (if applicable):

_____

_____

_____

_____

Additional Information

Please submit additional documental of services rendered, such as EVS verification or any other documentation that will support the request. Please include a typed narrative of additional supporting documentation to justify the request.