UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Provider Appeal Form

Please submit this form with documentation/medical records supporting your appeal.

Please choose your type of appeal:

CLEAR FORM

- ☐ **Claim Related**
- ☐ **Denied Authorization**
- ☐ **Payment Dispute**
  Disputing reimbursed amount
- ☐ **Increased Payment Request**
  Requesting additional reimbursement for complicated procedure.

NOTE: *To review your request, we require both medical records and an explanation from the provider describing the complicated procedure.*

Member Name:	**Provider Name:**
Member Number:	**Provider Number:**
Date of Service:	**Contact Name:**
Claim Number:	**Contact Phone Number:** **Contact Fax Number:**
Claimed Amount:	**Contact Address:**

Please provide a detailed description of your appeal:

Please Send Provider Appeal To: **ProviderAppeals@UofMHealthPlan.org**
517-364-8517 fax