Teachers Health Trust
Provider Adjustment/Appeal Request Form

Group Name / DBA _____ Tax ID # _____

Type of Request

- ○ Appeal — Claim was incorrectly denied or paid as out-of-network
- ○ Adjustment — Claim was paid incorrectly based on provider contract/fee schedule or plan benefits.

Provider Name/Acting Physician _____ NPI _____

Claim Number _____ Date _____ $ Total Claimed Amt. _____ $ Total Net Payment _____

Patient Name (Last) _____ (First) _____ (M.I.) _____ ID Number _____

For multiple claims, please document the details of each claim below.

	Claim Number(s)	DOS	Total Charge	Corrected Pmt. Amt.
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$

Please include any notes or documentation to help support your appeal.

I am attaching/enclosing supporting documents as follows (check all that apply)

- ☑ Copy of Provider Network Services Agreement, Fee Schedule and/or Payer Rate Sheet (recommended)
- ☑ Copy of EOB(s) documented above
- ☑ Copy of Operative Report
- ☑ Copies of any additional invoices, statements, etc.
- ☑ Other: _____

SUBMIT

Please e-mail this completed form, along with all supporting documentation and detailed description of appeal (if applicable), to the Network Relations Department at WH_NetworkRelations@hcpnv.com. Documents may also be faxed to 702-522-1357. Hard copies may be submitted to Teachers Health Trust, PO Box 96238, Las Vegas, NV 89193-6238. Please allow for longer response time if mailed.