TEACHERS HEALTH TRUST
For Teachers By Teachers

WELLHEALTH Quality Care
A MedSource Health Care Company

Provider Claims Appeal Request Form

Group Name / DBA _____ Tax ID # _____

Provider Name / Acting Physician _____ NPI _____

Claim Number _____ Date _____ $ Total Claimed Amount _____ $ Total Net Payment _____

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

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

	Claim Number(s)	Dates of Service	Total Charge	Payment Amount	Corrected Pmt Amount
1			$	$	$
2			$	$	$
3			$	$	$
4			$	$	$
5			$	$	$

Providers must include a detailed description to explain the Corrected Payment Amount listed above.

I am enclosing supporting documents as follows (check any and all that apply):

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

Please mail this completed form along with all supporting documentation and detailed description of appeal (if applicable) to the address below.

Teachers Health Trust
P.O. Box 96238
Las Vegas, Nevada 89193–6238