COMMUNITY FIRST
HEALTH PLANS

CLAIMS DEPARTMENT
APPEAL SUBMISSION FORM

Provider Name: _____ Date of Appeal: _____

Group Affiliation: _____

Address: _____

Provider Contact Name: _____ Provider Contact Number: _____

Member Name: _____ Member Number: _____

Date(s) of Service: _____ Claim Number#: _____

Reason for Review:

- ☐ Additional Payment Requested
- ☐ Copy of Referral attached
- ☐ Denied in Error
- ☐ Incorrect Units
- ☐ Other Health Insurance
  - Carrier: _____
  - Primary Insured Name: _____
  - Policy# _____ Group# _____
  - Effective Date: _____ Term. Date: _____
  - Contact Name: _____ Phone# _____
  - Date Verified: _____ Additional Notes: _____
- ☐ Authorization included/attached
- ☐ Date(s) of Service
- ☐ EOB Attached (COB claim)
- ☐ Resubmission with Proof of Timely Filing
- ☐ OTHER: _____

To expedite processing, return this form and a copy of the EOP, along with the any information related to appeal to:

Community First Health Plan
Attn: Claims & Appeals
PO Box 853927
Richardson, Texas 75085-3927