



# APPEAL FORM

Use this form as part of the Meridian Michigan request for formal appeal for re-evaluation or exception to a plan policy or contract requirement such as medical necessity, benefit limitations, eligibility, failure to obtain authorization or unsupported timely filing.

Name/ Address of person submitting appeal: Click or tap here to enter text.	Date: Click or tap here to enter text.
Provider Name: Click or tap here to enter text.	Provider Tax ID Number: Click or tap here to enter text.
Control/claim Number: Click or tap here to enter text.	Date(s) of service: Click or tap here to enter text.
Member Name: Click or tap here to enter text.	Member ID Number: Click or tap here to enter text.

### Reason for appeal:

- Claim was denied for no authorization, but authorization # \_\_\_\_\_ was obtained
- Claim was denied for no authorization, but no authorization is required for this service
- Claim was denied for untimely filing error (attach proof of timely filing)
- Claim was denied for global/ unbundled procedure (attach medical records)
- Claim was denied for benefit limitations
- Other (please explain):

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### Mail completed form and attachments to:

Meridian Michigan  
 Appeals Department  
 P.O. Box 8080  
 Farmington, MO 63640-4402