

This form is to be completed by providers, facilities, or ancillary health care professionals to request a formal appeal. If you are assisting a member who is filing an appeal because of an adverse claim or authorization determination (denial or disapproval) of requested services, please use the ***NMHC Appeal Request and Assignment of Authorized Representative Form***.

NOTES:

- Before filing an appeal, please review the "Claims Submission & Payment" section in the NMHC provider handbook to ensure filing an appeal is appropriate.
- If a claim has not been acted upon, i.e., not paid or formally denied, please verify claims status first.
- If the claim has been returned by NMHC for insufficient or incorrect information to be corrected, please submit this action before submitting an appeal.
- Provide relevant supporting documentation, including but not limited to: copy of claim, explanation of payment, medical records, and previous related correspondence. If sufficient information is not included, an appeal review will not be conducted.

PROVIDER/GROUP/FACILITY INFORMATION

Provider/Group/Facility Name:		
Provider TIN/NPI Number:		
Contact Name:		
Phone Number:	Fax Number:	
Email Address:		
Billing Address:		Apt./Suite #:
City:	State:	Zip Code:

MEMBER INFORMATION

Member Last Name:	First Name:
DOB:	Member ID Number:

CLAIM INFORMATION

<input type="checkbox"/> Provider	<input type="checkbox"/> Facility	<input type="checkbox"/> Ancillary Health Care Professional (DME, lab, etc.)
Claim Number (if applicable):	Authorization # (if applicable):	DOS:
Billed Amount:	Paid Amount:	

Reason (Select a reason from the drop-down menu below):

Other- Please Enter Reason below

State Reason for Appeal:

SUBMISSION OPTIONS: MAIL, FAX, EMAIL

Mail: New Mexico Health Connections, Attn: Appeal Department, P.O. Box 36719, Albuquerque, NM 87176-9907

Fax: Attn: Appeal Department 1-800-747-9132 **Email:** NMHC-Provider-A-and-G@mynmhc.org