new mexico health connections

PROVIDER PAYMENT APPEAL REQUEST FORM

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:		
Address:		**Apt./Suite #:**
City:	**State:**	**Zip Code:**

MEMBER INFORMATION	
Last Name:	**First Name:**
DOB:	**Member ID Number:**

CLAIM INFORMATION		
☒ **Provider**	☐ **Facility**	☐ **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):

Lack of Medical Necessity

State Reason for Appeal:

SUBMISSION OPTIONS: MAIL, EMAIL

Mail: New Mexico Health Connections, Attn: Appeal Department, P.O. Box 30707, Albuquerque, NM 87190

E-mail: appeals @mynmhc.org