COMMUNITY FIRST
HEALTH PLANS

CLAIMS DEPARTMENT APPEAL SUBMISSION FORM

Invalid or incomplete information will result in a rejection or denial (* indicates a required field).

PROVIDER INFORMATION

*Provider Name: *Date of Appeal:

Group Affiliation:

*Address: Suite:

*City: *State: *Zip: *Phone/Extension:

*Provider Contact Name: *Provider Email:

MEMBER INFORMATION

*Member Name: *Member ID #:

*Date(s) of Service: *Claim #:

Line of Business: STAR STAR Kids STAR+PLUS CHIP University Family Care Plan
Medicare Advantage Commercial Health Exchange

REASON FOR REVIEW:

Additional Payment Requested
Authorization included/attached
NDC Denial
Contract Issue
Denied in error (explain below)
EOB attached (COB claim)
MUE Denial
Resubmission (with proof of timely filing)

Other Health Insurance (please provide the information requested below):

Carrier: Effective Date: Term Date:

Primary Insured Name: Group #: Policy #:

Contact Name: Phone/Extension: Date Verified:

Additional notes:

Other (please explain):

Mail completed paper claims appeal form to:
Community First Health Plans
P.O. Box 240969
Apple Valley, MN 55124