Provider Claims Review Form

Please note this form is not for Member use

(Use a separate form for each patient)

Date:

Provider Information			
Provider Name:			
Provider Tax ID			
Contact Name:			Signature:
Telephone:			Fax:
Address:			
City:	State:		Zip:

Provider Type			
☐ Professional	☐ Institutional	☐ Skilled Nursing Facility	☐ Assisted Living Facility
☐ DME	☐ Home Health	☐ Ambulance	☐ Other (please specify)

Claim Information		
Enrollee Name:		
Enrollee ID:		Enrollee Date of Birth:
Claim Number(s):		Authorization Number:
Date of Service From		Date of Service To

Reason for Review		
☐ Previously Denied for Untimely Filing	☐ Previously denied for Additional Information	☐ Previously denied for Coodrdination of Benefits
☐ Corrected Claim (please specify correction)	☐ Claim was denied as a duplicate claim	☐ Previously processed but contracted rate applied incorrectly
☐ Other (please specify)		

Comment

Supporting Documentation		
☐ Medical Equipment Invoice	☐ Explanation of Benefits (EOB)	☐ Copy of Primary Insurer's Remittance advise
☐ Original Claim Form	☐ Proof of Timely Filing	☐ Itemized Bill
☐ Other (please specify)		

Please return completed form with all relevant supporting documentation to: Simply Healthcare Plans, Claims Department, 9250 W. Flagler Street, MS 100, Suite 600, Miami, Fl. 33174-3460