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 ☐ CHIP ☐ 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