Claim Appeal Form

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal.
Note: This form is NOT required for the submission of appeals but is recommended for a quicker response time.

Provider Name	Provider Tax ID
Provider NPI	State where inmate is housed
Centurion Claim Number	Dates of Service
Inmate Name	Inmate ID

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for Medicaid responsibility in error.
- ☐ Claims was denied for member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Centurion (attach relevant reimbursement section).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - *Note: If the past timely filing deadline denial falls on a weekend or holiday, the provider may request a reconsideration.*
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- ☐ Other. Please explain (and provide supporting documentation):

_____

_____

_____

Please ensure sufficient details are provided to assist us in the review of your appeal.

For appeals regarding authorization or medical necessity denials email completed forms and all attachments to: Centurionappeals@teamcenturion.com **or fax to 888-755-3561.**

All other appeals and disputes should be emailed to centurionbilling@teamcenturion.com **or fax to 573-755-0702.**

Contact name, email or fax number of the person requesting the appeal: _____