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APPEAL FORM COVER LETTER

Use this form as part of the Meridian Michigan Request for Formal Appeal for re-evaluation or exception to a plan policy or contract requirement, such as medical necessity, benefit limitations, eligibility, failure to obtain authorization or unsupported timely filing.

Name/ Address of person submitting appeal:	Date:
Provider Name:	Provider Tax ID Number:
Control/claim Number:	Date(s) of service:
Member Name:	Member ID Number:

Reason for appeal:

☐ Claim was denied for no authorization, but authorization # _____ was obtained
☐ Claim was denied for no authorization, but no authorization is required for this service
☐ Claim was denied for untimely filing error (attach proof of timely filing)
☐ Claim was denied for global/unbundled procedure (attach medical records)
☐ Claim was denied for benefit limitations
☐ Other

Other:

Mail completed form and attachments to:
Meridian Michigan
Appeals Department
P.O. Box 8080
Farmington, MO 63640-4402

Fax completed form and attachments to:
Michigan Medicaid Post-Service Appeals - 833-592-0658

In order for your appeal to be processed via Fax please ensure the following is submitted:

- Appeal Cover Page including the claim number being appealed
- Appeal letter