



Medicare Non-Contracted Provider Appeal Form

This form is to request a review of a denied claim or a denied pre-service request for benefits. Make sure to include any information that will support your appeal. This may be medical records, office notes, discharge summaries, lab records, member history and/or any other pertinent information.

Member Information	
Member First Name	Member Last Name
Member ID# (found on Member ID card)	Date of Birth (MM/DD/YYYY)

Provider Information		
Provider Name	NPI/TIN	
Contact Name and Title		
Contact Mailing Address (where appeal resolution should be sent)		
Contact Phone	Contact Fax	Contact Email Address

Appeal Information <i>(This information may be found on the front of your Explanation of Payment or letter of denial.)</i>	
Claim Number or Authorization Number	Date of Service (MM/DD/YYYY)
Initial Denial Notification Date	Appeal Denial Notification Date
CPT/HCPC/Service Being Disputed	

Please include an explanation of your appeal and a statement of the action you would like taken in response to your appeal. Attach any and all documentation (written comments, records, or other documents) that may support your appeal. **This appeal must be filed within 65 days of the date on the Explanation of Payment or letter of denial of coverage/authorization.** You will receive a written response within the Medicare timeframe. For more information, contact Member Services at (563) 584-4885, or toll free at 1-866-821-1365, or by email to MemberServices@mahealthcare.com.

Are there documents attached? Yes No Waiver of Liability (WOL) attached? Yes No

Return completed form to:
Member Services Department
Medical Associates Health Plan, Inc.
1605 Associates Drive, Suite 101
Dubuque, IA 52002

Fax: (563) 584-4760
E-mail: MemberServices@mahealthcare.com



Medical Associates Health Plans (MAHP) Waiver of Liability Statement

Member's Name _____

MAHP Member's ID _____

Provider Name _____

Health Plan Medical Associates Health Plans _____

Date(s) of Service _____

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Provider Signature _____

Date _____

