PROVIDER APPEAL

This form is to be submitted by providers who are disputing their contractual rates, pricing and/or participation status with below mentioned networks. For all other appeals, please submit your request for review to appeals@consolidatedhealthplan.com.

Date:

Provider Information:

Name of Facility:

Tax Identification Number:

Contact Name: Contact Phone #:

Facility Address:

Claim Details:

Claim Number: Member ID#:

Date(s) of Service: Billed Charges:

Please select the appropriate network:

Cigna	MagnaCare	MultiPlan	PHCS	Cofinity
MedCost	The-Alliance	Zelis/PHX Edits	CHP PPO	
OccuNet	First Health			

Additional Details:

****Please be advised that your cleanly submitted appeal will be sent to the appropriate network(s) for review upon 48-72 hours of receipt. If you'd like to check the status on an appeal, please email providerappeals@chpemail.com****