



Contracted Provider Reconsideration (Appeal) Form

Contracted Fresenius Health Partners providers must file an appeal for claim payment denials within 180 calendar days of the initial Fresenius Health Partners Explanation of Payment (EOP). Please visit our web site for detailed information regarding the appeals process. If you are not a contracted Fresenius Health Partners provider, please utilize the Non-Contracted Provider Appeal form available on our web site. If you are a treating physician wanting to appeal a Pre-Service Denial on behalf of a member, please visit the Member Appeals & Grievances section on our web site for detailed information regarding the member appeals process.

Complete all fields, attach appropriate documentation, and mail or fax to:

Fresenius Health Partners
Attn: Contracted Provider Appeals
7100 Commerce Way, Suite 285
Brentwood, TN 37027
Fax Number: (615) 250-1711

Check Reason for Reconsideration:

- Prior authorization not requested
- Authorization does not cover services rendered
- Prior authorization denied and provider proceeded to render services

DATE: _____ PROVIDER NAME: _____

ADDRESS (Street, City, and Zip): _____

Tax ID: _____ PHONE # : (____) _____ FAX # : (____) _____

CONTACT NAME: _____

CLAIM INFORMATION: (Please complete one form per member.)

PATIENT NAME: _____

PATIENT ID #: N _____ DATE(S) OF SERVICE: _____

CLAIM # _____ BILLED AMOUNT: \$ _____

REQUEST FOR REVIEW: (Indicate the reason(s) this claim should be reconsidered. If you failed to obtain prior authorization, please explain why.)

The following attachments are required:

1. Supporting documents (operative reports, med records, chart notes, Medicare EOB, etc.)
2. Copy of claim form
3. Fresenius Health Partners initial EOP
4. Proof of eligibility verification or explanation of why eligibility verification was not obtained (if applicable to reason for reconsideration)

UNTIMELY OR INCOMPLETE APPEAL REQUESTS WILL NOT BE CONSIDERED.