Simplified Benefits Administrators Appeal Form

Type of Appeal

- ☐ Clinical Appeal
- ☐ Claim Appeal
- ☐ Medical Necessity

Date of Appeal:_____

Provider Information		
Provider Name:		TIN:
Facility Name:		NPI:
Address:		Phone Number:
Patient Information		
Patient Name:	ID #:	DOB:
Claim Information		
Claim Number:	Billed Amount:	Date of Service:
If clinical appeal, authorization or precertification number:		
Please explain the reason for your appeal below:		
Supporting Documentation		
Please attach the applicable supporting documentation: 1. Copy of the remittance advice or explanation of benefits, indicate the code(s) or service(s) being appealed 2. Medical documentation related to the appeal (medical records, operative report, medical necessity, etc.) 3. Proof of timely filing 4. Any other supporting documentation applicable related to this appeal		

_____ _____

Signature Date

_____ _____

Printed name of patient or patient's representative Email Address

Please submit the form using one of the following options.
Email: customerservice@simplifiedbenefitsadministrators.org
Fax: 801.442.0041