

# CLAIM APPEAL FORM

All fields are required. If information is missing, the appeal will not be processed and will be returned to the address listed on the form below.

- Colorado Access Advantage       Access Behavioral Care       Access Health Colorado  
 CHP+ offered by Colorado Access       CHP+ State Managed Care Network       Behavioral Healthcare, Inc.

**COMPLETE A SEPARATE REQUEST FOR EACH RECIPIENT AND/OR CLAIM. INCLUDE THE FOLLOWING:**

1. A copy of the claim in question
2. A copy of the voucher showing the recent payment
3. Medicare/Third Party Liability - a copy of the Explanation of Benefits
4. Other documentation as necessary
5. If you are making this appeal on the member's behalf, include an Authorization of Representative form

Provider Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**ALL FIELDS BELOW MUST BE COMPLETED**

Member ID: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Member Name: \_\_\_\_\_

Voucher Date: \_\_\_\_\_

Billed Amount: \_\_\_\_\_

Billing Provider TIN: \_\_\_\_\_

Claim Number: \_\_\_\_\_

**DESCRIBE REQUEST (YOUR DESCRIPTION MUST INCLUDE ANY PROCEDURE CODES/UNITS/AMOUNTS, ETC.)**

Date: \_\_\_\_\_

By (Provider Authorized Signature): \_\_\_\_\_

**Mail request to:**

Colorado Access Appeals  
PO Box 17189  
Denver, CO 80217

**TO BE COMPLETED BY COLORADO ACCESS**

Reprocess to pay

Reprocess to deny

Void original claim

Comments: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_



coaccess.com  
1-800-511-5010



accesshealthco.com  
1-855-325-9426