

**PROVIDER APPEAL AND CLAIMS INQUIRY FORM**

If you disagree with a denial or reduction of benefits by St. Luke's Health Plan, or the way a claim was processed, use this form to request an appeal or dispute a payment decision.

**REASON FOR DENIAL OR REDUCTION:**

Not medically necessary

Service deemed experimental or investigational (E&I)

No prior authorization obtained

Application of coding edits

Other coding issue (please specify): \_\_\_\_\_

**IMPORTANT:** Denials based on benefit limits and benefit exclusions, as well as denials of Higher Level of Benefits waivers, must be appealed *by the member*. These denials cannot be appealed by a provider, unless the provider has been formally appointed by the member as an authorized representative for the member's appeal.

**PROVIDER CONTACT INFORMATION:**

Date:	Provider Name:		
Office Contact:	Contact Phone Number:		
Office Address:	City:	State:	Zip:

**CLAIM INFORMATION:**

Subscriber ID:	Patient Name:
Dates of Service: _____ to _____	
Claim #:	Authorization #:
Denial reason code(s):	
Notes attached?    Yes    No <i>All appeals require the submission of notes or other supporting documentation.</i>	

**Send completed forms via email or mail:**

**Fax:** 208-385-3760

**Email:** customerservice@slhealthplan.org

**Mail:** ATTN: Customer Service, St. Luke's Health Plan,  
PO Box 1739, Boise, ID 83702-5809

Questions? Call Customer Service at **833-840-3600**.