Summit COMMUNITY CARE

Claim Payment Appeal Form

Member information					
Member first and last name:					
Subscriber ID:		Member DOB:			
Provider/provider representative information					
Provider first and last name:					
TIN:					
Provider street address:					
City:		State:		ZIP code:	
☐ I am a participating provider.		☐ I am a nonparticipating provider.			
Provider representative					
☐ Self	☐ Billing agency	☐ Law firm	☐ Other: _____		
Contact name:					
Contact phone:					
Street address:					
City:		State:		ZIP code:	
Email address:					
Claim information*					
Claim #:					
Billed amount:	$	Amount received:	$		
Start date of service:		End date of service:			
Authorization #:					

*For multiple claims related to the same issue, providers can use one form and attach a listing of the claims with each supporting document. **This form is a required attachment for all claim payment appeals.**

All services referenced in this material are funded and provided under an agreement with the Arkansas Department of Human Services.
ARPEC-0454-19 September 2019

Payment appeal

All appeals must be submitted in writing or via our provider website. We accept payment appeals within 30 calendar days of the date the reconsideration determination was mailed (if one was filed) or within 30 calendar days of the date on your *Explanation of Payment (EOP)*. A payment appeal is defined as a request from a health care provider to change a decision made by Summit Community Care related to a claim payment for services already provided. A provider payment appeal is not a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a *Notice of Action*. Providers may include testimony in addition to evidence and legal and factual arguments when submitting appeals. Providers may also have their case file — including medical records, other documents and records, and any new or additional evidence — considered, relied upon or generated by Summit Community Care in connection with the appeal.

If a reconsideration is already in process but a reconsideration determination has not been generated and sent, we will treat this request for an appeal as a request to terminate the reconsideration process and move forward with the appeal.

Payment reconsideration reference number (if applicable):	

Reason for appeal

To ensure timely and accurate processing of your request, please check the applicable determination provided on the *Determination Letter* or *EOP*:

☐ Untimely filing ☐ No authorization ☐ Denied for other health insurance (OHI), but member doesn't have OHI ☐ Experimental/investigational procedure denial	☐ Claim code editing denial ☐ Retrospective authorization issue ☐ Disagree that you were paid according to your contract ☐ Data elements on the claim on file does not match the claim originally submitted	☐ Denied as duplicate ☐ Denial related to provider data issue ☐ Member retro-eligibility issue ☐ ER level of payment review ☐ Other: _____

Mail this form (or upload if filing a web appeal), a listing of claims (if applicable) and supporting documentation to:

Payment Dispute Unit
Summit Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429