PROVIDER APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant Leon to re-evaluate its original decision. Appeal requests must include claim numbers and supporting documentation (ie: copies of medical records). Review of claims does not guarantee a change in payment. For Non-Participating providers: a Waiver of Liability is required when initiating an appeal. The Waiver of Liability form may be obtained at the following link: http://www.lmchealthplans.com/English/Forms/WaiverLiabilityStatement.pdf

Provider name ________________________________ Provider TIN________________

Contact ____________________ Phone_________________ Fax _______________

Member Name _________________________

Leon Member ID Number ________________

Member Address:_______________________________

Claim Number ____________

Date of Service ____________

Reason for Appeal:

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Please mail this form attention to:

Leon Medical Centers Health Plans
Appeals Department
P.O. Box 66-9440
Miami, FL 33166

You can also fax your appeal request to (305)229-7500 or contact our department at (305)631-5348.

Physician's Signature: __________________________ Date: _____________

07/2016