PROVIDER APPEAL FORM

Appealing Party: Member, a person acting on behalf of the member; member's physician or health care provider. Please complete applicable sections below.

Name:

Address:
Phone #: _____ Fax #:

Specialty:

Member:

Name: _____ CFHP ID:

Type of Appeal:

PLEASE SUBMIT ALL PERTINENT INFORMATION REGARDING THE APPEAL, INCLUDING MEDICAL RECORDS. THIS WILL AVOID ANY ADDITIONAL DELAY IN REVIEWING THE APPEAL. **THIS FORM MUST BE COMPLETED AND RETURNED TO COMMUNITY FIRST IN ORDER FOR YOUR APPEAL TO BE REVIEWED AND RESOLVED.**

_____

Signature of Appealing Party Date