MERCYCARE HEALTH PLANS & MERCY PHYSICIAN ASSOCIATION
PROVIDER APPEAL FORM

Date Appeal Requested:	**Member Number:**
Member Name:	**MercyCare Claim Number:**
Member DOB:	**Group Number:**
Group Name:	**Total Claim Amount:**
Date(s) of Service:	**CPT Code(s):**
Claim Amount in Question:	
Revenue Code(s):	**Dates billed:** **Date of Claim remittance:** **Denial Code on EOB:**

Description of Request

Type or print your name**:**
Type or print your mailing address (to include facility name):
Type or print your direct phone number: