Ascension **Personalized Care**

Post service appeal request form

Indiana ____ Kansas ____ Tennessee____ Texas_____

If you are a member submitting an appeal, please complete the information below and include any additional medical records or documentation to support your appeal. If you have a copy of the claim or the Explanation of Benefits (EOB) please include a copy with your submission. If you are a doctor submitting a claim on behalf of a member, please include a copy of the EOB, a copy of the claim and any/all medical records and/or documentation to support your request for the appeal.

Please complete the following information:

Appeal is being filed by: Member ____ Doctor ____ Facility ____
Other Representative _____

If other representative is selected, please indicate relationship to the member and include a signed personal representative form or your appeal will be returned.

Today's date	*Group name*

Member's first name	*Member's last name*	*Member's ID number*
Patient's first name	*Patient's last name*	*Patient's date of birth*
Name of doctor	*Doctor's TIN/NPI*	*Doctor's phone number*
Doctor's address		

Claim number	*Claim date of service*

CPT/HCPCS/Service being disputed
Explanation of your request (please submit additional pages if necessary)

Please email your *Post Service* appeal with this form to: appeals_fax@abs-tpa.com
You may also mail your appeal to:
US Health and Life Insurance Company
PO Box 1707
Troy, MI 48099-1707

Ascension Personalized Care benefits are underwritten by US Health and Life Insurance Company.

Ascension