# Ascension **Personalized Care**

## Post service appeal request form

Indiana ____ Kansas ____ Michigan ____ 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 ____ Physician ____ Facility ____ Other Representative ____

If other representative is selected, please indicate relationship to member:

______________________________________________________________________________

| *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 provider* | *Provider's TIN/NPI* | *Provider's phone number* |

| *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:** **Appeal_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.