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 EMP to re-evaluate its original decision.

- An appeal request must include claim numbers and supporting documentation; *e.g.*, complete copy of the medical records and claim form.
- Review of a claim does not guarantee a change in payment disposition.
- An acknowledgment letter will be sent to you within ten (10) calendar days upon receipt of the Appeal Form

Date: ______________________________________

Provider name: _____________________________________Provider ID number or TIN__________________________

Phone____Contact____

Fax____

Address____

Member name ____ Member ID number_______________________________

Claim number____ Date of service / /

Reason for Appeal (attach supporting documentation)

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Please attach a copy of the inquiry determination form.

Mail completed form and attachments to:

EMP Medical Services, Inc.
2850 Douglas Road, 3rd Floor
Coral Gables, FL 33134
Attention: Provider Claims Appeals