



**Provider Claims Review Form**  
Please note this form is not for Member use  
(Use a separate form for each patient)

Date:

Provider Information			
Provider Name:			
Provider Tax ID			
Contact Name:		Signature:	
Telephone:		Fax:	
Address:			
City:	State:	Zip:	
Provider Type			
<input type="checkbox"/> Professional	<input type="checkbox"/> Institutional	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Assisted Living Facility
<input type="checkbox"/> DME	<input type="checkbox"/> Home Health	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Other (please specify)
Claim Information			
Enrollee Name:			
Enrollee ID:		Enrollee Date of Birth:	
Claim Number(s):		Authorization Number:	
Date of Service From		Date of Service To	
Reason for Review			
<input type="checkbox"/> Previously Denied for Untimely Filing	<input type="checkbox"/> Previously denied for Additional Information		<input type="checkbox"/> Previously denied for Coordination of Benefits
<input type="checkbox"/> Corrected Claim (please specify correction)	<input type="checkbox"/> Claim was denied as a duplicate claim		<input type="checkbox"/> Previously processed but contracted rate applied incorrectly
<input type="checkbox"/> Other (please specify)			
Comment			
Supporting Documentation			
<input type="checkbox"/> Medical Equipment Invoice	<input type="checkbox"/> Explanation of Benefits (EOB)	<input type="checkbox"/> Copy of Primary Insurer's Remittance advise	
<input type="checkbox"/> Original Claim Form	<input type="checkbox"/> Proof of Timely Filing	<input type="checkbox"/> Itemized Bill	
<input type="checkbox"/> Other (please specify)			

Please return completed form with all relevant supporting documentation to: Simply Healthcare Plans, Claims Department, 9250 W. Flagler Street, MS 100, Suite 600, Miami, FL 33174-3460