New York Network IPA, Inc.
Claims Form

Provider Name:	
Practice:	
Member last name, first name:	
Member ID #:	
Insurance Plan:	
Claim #:	
DOS:	
Detailed reason for denial:	

Please attach a copy of the claim (HCFA or print out from Claimschannel360) and any supporting documentation (Check the appropriate squares below):

- ☐ Authorization numbers/cover letters
- ☐ Proof of timely submission
- ☐ Copies of primary EOB
- ☐ Medical notes
- ☐ Member eligibility proof (screenshots or other)
- ☐ Member ID card copy
- ☐ Copy of invoice(s)
- ☐ Patient consent forms
- ☐ Referrals
- ☐ Corrected claim forms
- ☐ Other

As of December 5th 2011 ALL APPEALS and CORRECTED CLAIMS MUST GO TO THE NEW PO BOX:

NYNM IPA Appeals/COB
PO BOX 640
LAKE KATRINE NY 12449