

New York Network IPA, Inc. Appeals 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