Provider Payment Appeal Request Form

This form is to be completed by providers, facilities, or ancillary health care professionals to request a formal appeal. If you are assisting a member who is filing an appeal because of an adverse claim or authorization determination (denial or disapproval) of requested services, please use the Appeal Request and Assignment of Authorized Representative Form.

NOTES:

- Before filing an appeal, please review the "Claims Submission & Payment" section in the True Health New Mexico Provider Handbook to ensure filing an appeal is appropriate.
- If a claim has not been acted upon, i.e., not paid or formally denied, please verify claims status first.
- If the claim has been returned by True Health New Mexico for insufficient or incorrect information to be corrected, please submit this action before submitting an appeal.
- Provide relevant supporting documentation, including but not limited to: copy of claim, explanation of payment, medical records, and previous related correspondence. If sufficient information is not included, an appeal review will not be conducted.

PROVIDER/GROUP/FACILITY INFORMATION		
Provider/Group/Facility Name:		
Provider TIN/NPI Number:		
Contact Name:		
Phone Number:	Fax Number:	
Email:		
Address:		Apt./Suite #:
City:	State:	Zip Code:

MEMBER INFORMATION	
Last Name:	First Name:
DOB:	Member ID Number:

CLAIM INFORMATION		
☐ Provider	☐ Facility	☐ Ancillary Health Care Professional (DME, lab, etc.)
Claim Number (if applicable):	Authorization # (if applicable):	DOS:
Billed Amount:	Paid Amount:	

Reason (Select a reason from the drop-down menu below):

Other: Please Enter Reason Below

State Reason for Appeal:

SUBMISSION OPTIONS: MAIL & FAX

Mail: True Health New Mexico, Attn: Appeal Department, P.O. Box 37200, Albuquerque, NM 87176-9907
Fax: Attn: Appeal Department 1-800-747-9132