



JOHNS HOPKINS HEALTHCARE Rejection Review - Appeals Form

Provider Name and Group _____ **Date** _____

Contact Name _____ **Contact Phone Number** _____

JHHS Rejection Review Information

Providers: Please fill out all the fields.

Patient's Name _____ **I.D. Number** _____

Date of Service _____ **Claim Number** _____

Line of Business - PP EHP USFHP Date Rejected _____

(Please circle)

Reason for Rejection Review

Send to APPEALS Department: Providers - please check the appropriate box.

Not Authorized **ER Notes Attached**
(Attach referral)

Code Review **Other**
(Clinical notes must be attached) (Must have comments attached)

Send to ADJUSTMENTS Department: Providers - please check the appropriate box.

Eligible per EVS (Provide MA #) **Rejected Untimely Claim Filing**
(Attach proof of timely filing)

Itemized Bill Requested **Corrected Claims**

EOB Requested (Attach UB 04 or CMS 1500) **Overpaid/Underpaid Amount**

Duplicate Claim **PPMCO Profees for ER**

Send to CLAIMS Department: Providers - please check the appropriate box.

Late Charges **Other (Comments must be attached)**

DO NOT REMOVE THIS FORM FROM ATTACHED DOCUMENTATION