



Appeal/Medical Review Submission Form

All information must be submitted in writing to Health First Network for payment consideration at the address below. Appeals will not be accepted by email or fax.

Health First Network
PO BOX 10786
Pensacola FL 32524-0786

Appeal Timelines: Timely submission calculated from the EOB date of the claim denial.

Please select the insurance applicable to the appeal submission:

- Wellcare, Healthsease, Vista, Vista Healthy Kids, HealthSpring

Provider of Service (Physician or Facility)

Address (number, city, state, zip)

Telephone Fax

Contact Person Date

Member Name Member ID

Original Claim Number Date of Service

Type of Appeal:

Type of Medical Review:

- Payment Issue, Unlisted Code, PCP Issues, Eligibility Issue, Requested Documentation attached, Other, Modifier Issue, Unlisted Code, Authorization issue, Requested Documentation Attached, Other

All requests for reconsideration require a detailed explanation. Be sure to attach all supporting documentation: i.e. copy of denial from EOB, copy of original claim, copy of electronic claim submission confirmation form, pertinent clinical documentation etc.

Horizontal lines for providing detailed explanation and supporting documentation.