



Appeal Submission Form

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

**Health First Network
PO BOX 10786
Pensacola FL 32524-0786**

Appeal Timelines Attached: All received dates for appeals are based on the EOB date of the original claim

Please select the insurance applicable to the appeal submission:

- Wellcare (must be received w/in 60 days from date of original denial)
- Coventry/ Vista (Par providers -45 days from date of original denial, Non par -1yr)
- Coventry Healthy Kids (Par providers -45 days from date of original denial, Non par -1yr)
- HealthSpring (180 days from date of original denial)

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:

- Payment Issue Timely Filing PCP Issues Eligibility Issue Requested Documentation attached Other

Please provide a detailed explanation of the appeal (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 etc).

